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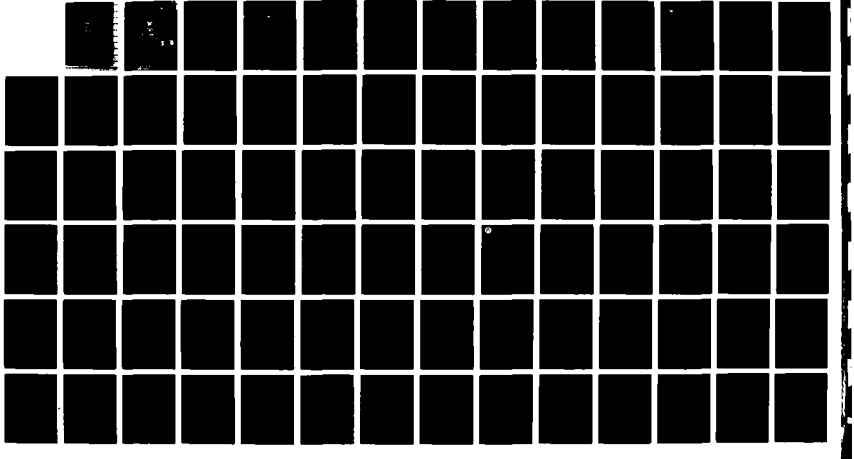

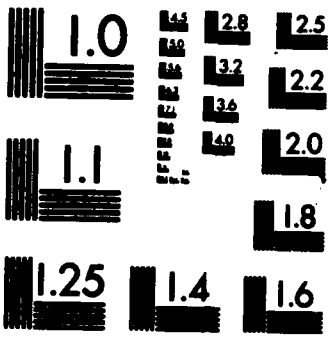

AIR COMMAND AND STAFF COLLEGE

STUDENT REPORT

THE HOSPITAL ORGANIZATIONAL STRUCTURE AND THE DEPARTMENT OF NURSING IN THE UNITED STATES AIR FORCE

MAJOR DEBORAH A. HART 87-1120

"insights into tomorrow"

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TITLE THE HOSPITAL ORGANIZATIONAL STRUCTURE AND THE DEPARTMENT OF NURSING IN THE UNITED STATES AIR FORCE.

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Air Force Chief Nurses are currently functioning in a variety of organizational structures; many of which do not comply with criteria established by AFR 168-4. The purpose of this study is to establish similarities or differences, using data received from an approved survey, between the chain of command and authority lines within Air Force medical facilities, and to discover if current, on-line organizational policies and procedures are effective. The study concludes that 99% of the nurse respondents want to be equal members of the hospital's executive management team. This study recommends revision of AFR 168-4 to mirror these responses.

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PREFACE

This project will address the Air Force Nurse Corps' perceived problems with their current organizational responsibility - authority gap in relationship to other Hospital executive staff members. These lines of communication and authority are depicted in AFR 168-4. Currently, Chief Nurses are not all functioning within the prescribed guidelines. In reality, there seems to be little continuity among the force, leading to confusion, discontent, and poor self-image. Command Surgeon's and Hospital Commander's have the power of the pen to yea or nay a Chief Nurses' move from working for the Chief of Hospital Services, as a subordinate, to working with the Chief of Hospital Services, as a peer. The Hospital, an atmosphere where team work is essential, finds friction and power struggles present because of current role discrepancies. This project will explore the Department of Nursing's current locations within the organizational structure in our Air Force medical facilities. What is really happening? Are there problems which need to be identified and worked on? Are the nurses currently functioning in Chief Nurse roles able to get the job done? These will be some of the questions addressed in this paper.

The Chief Nurse of the Air Force Nurse Corps, Brigadier General Schimmenti, suggested I pursue this topic for "our Corps". I jumped in with both feet and have enjoyed an overwhelming response from the senior Nurse Corps leaders. The responses were enlightening and will be shared by the entire Corps.

This project is a compilation of data provided by current medical treatment facility Chief Nurses. The results and recommendations are not my own, but reflect the thoughts and feelings of 74% of our current management/leadership force. Hopefully, this paper will provide the background information necessary to knowledgably address the current situation.

CONTINUED

ACKNOWLEDGMENTS

As with patient care, one does not work alone. This project is not an exception. First, to Brigadier General Schimmenti, the project's sponsor. No doubt my telephone call to you last September was unexpected. Many thanks for your excellent suggestion. I only hope this will fill the bill. Mrs Pat DeGraff, secretary to B/Gen Schimmenti, was a terrific help. Her time spent over the hot Xerox machine will be ever appreciated and her friendly voice on the phone was a joy to behold for a ASCS student. Now for the local folks. Lt Col M. Mantel, my advisor, and Maj Fred Chapman, my first FI, have never once made me "fight for feedback". They have both been there when I needed them, with red pen in hand. You both kept me on the right path. Thanks so much to both of you, your never ending patience is admirable. Finally, but not least, a special thanks to Col Michael H. Bednarz. Without your true interest and caring in my success, and your unrelentless editing expertise, I'd still be looking for the power curve.

ABOUT THE AUTHOR

Major Deborah A. Hart, graduated from the University of Kentucky with a Bachelor of Science Degree in Nursing in 1974. She received her Commission through the University's Air Force ROTC program as a Distinguished Graduate. Her initial tour of duty was at USAF Medical Center Scott, Scott AFB, Illinois as a Staff Nurse.

Her Nursing experiences include a wide variety of nursing and adminintrative positions. Pediatrics, Hematology/Oncology, Hospital Quality Assurance, the 656th TAC Hospital, and Assistant Chief Nurse are but a few of her Air Force experiences. Maj Hart completed a Master's Degree in Education and Counseling (MSEd) with Boston University. Additionally she has completed Squadron Officer's School and Nursing Service Management in residence. An active member of the American Cancer Society, she has lectured on topics related to Cancer Detection and Prevention. Maj Hart is currently a member of the Air Command and Staff College class of 1987. Following graduation, she plans a follow-on tour at Wilford Hall Medical Center, San Antonio, Texas.

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EXECUTIVE SUMMARY

Part of our College mission is distribution of the students' problem solving products to DoD sponsors and other interested agencies to enhance insight into contemporary, defense related issues. While the College has accepted this product as meeting academic requirements for graduation, the views and opinions expressed or implied are solely those of the author and should not be construed as carrying official sanction.

"insights into tomorrow"

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AUTHOR(S) MAJOR DEBORAH A. HART, USAF, NC

TITLE THE HOSPITAL ORGANIZATIONAL STRUCTURE AND THE DEPARTMENT OF NURSING IN THE UNITED STATES AIR FORCE.

I. Purpose: To establish similarities or differences, using data received from an approved survey, between the chain of command and authority lines within Air Force medical facilities, and to discover if current, on-line organizational policies and procedures are effective.

II. Problem: Air Force Chief Nurses are currently functioning within a variety of organizational structures. Many of these do not fit the criteria established by AFR 168-4. For this reason, there seems to be confusion and discontent among the Nurse Corps' senior leaders. However, the more apparent problem stems from nursing's place within the hospital's organizational structure. Currently, the regulation places the Department of Nursing subordinate to all other major departmental chiefs. This is in light of the fact that nursing usually has the greatest number of personnel assigned, the largest budget, responsibility for the greatest portion of the hospital, and a major role in the Hospital's primary mission of quality patient care. Chief Nurses currently function under the direction of the Chief, Hospital Services, a physician. These senior nurse leaders feel their responsibilities within the hospital require equal billing with the other chiefs. Credibility, decision making ability, and self-esteem are suffering because of their lack of authority. The Chief Nurse of the United States Air Force Nurse Corps, Brigadier General Schimmenti, suggested I investigate this particular area and discover if the problem is real or perceived.

CONTINUED

III. Data: An 11 question survey was sent to 123 Air Force Chief Nurses. These questions dealt with such topics as size of facility, number of personnel supervised, current inspection results, and personal feelings dealing with current system effectiveness and suggestions for positive change. 91 Chief Nurses responded; 74%. Their responses were manually grouped according to question and all written responses appear, unaltered, in Appendices 3-1, 3-2, and 3-3. The data did not lend itself to mathematical calibration.

IV. Conclusions: 99% of the Chief Nurse respondents want to be equal members on the hospital's executive management team. Responses covered subjects such as: mandatory nursing management training for all chief nurses; no one knows how to manage and lead nurses better than nurses; the Chief, Hospital Services does not really have the time, training, or inclination to adequately supervise the Department of Nursing; nurses are held accountable and responsible for the care of all types of patients, but are not always given the authority to make decisions to ensure these things are possible; and, team work is the key to quality patient care and the Department of Nursings' equal standing within the hospital's management structure is a way to guarantee this product.

V. Recommendations: Ammend AFR 168-4, to show the Department of Nursing as an equal member within the executive management team. This would provide the Chief Nurse with a three-letter office symbol; SGN. Suggestions for additional studies effecting the Department of Nursing and the Hospital's organizational structure are listed.

Chapter One

INTRODUCTION

WHAT'S IT ALL ABOUT?

The United States Air Force currently staffs eight medical centers, ten regional hospitals, 66 hospitals, 38 clinics, and one aid station in the Continental United States and overseas. The Air Force Nurse Corps (AFNC) provides Chief Nurse support at each of these facilities and supports the Wing and Air Force Medical Service mission. "The mission of the Air Force Medical Service is to provide the medical support needed to maintain the highest degree of combat readiness and effectiveness of the Air Force (12:2-1)." Air Force Regulation 168-4, "Administration of Medical Activities", provides guidance for the organizational structure of all medical treatment facilities (MTF). Section K - Hospital Services deals with nursing's placement in the chain of command and authority within the MTF structure. In general, the Chief Nurse/Director of Nursing Services (CN/SGHN) reports through the Chief, Hospital Services (SGH), a physician, to the Director of Base Medical Services/Hospital Commander (DBMS/SG), also, usually a physician. A critical review of all hospital organizational charts, especially Chart 3-1 and Chart 3-2 (Appendix 1-1 and 1-2), shows nursing is the only major service to fall below their professional peers in the organizational structure. That "extra" step between the CN and the DBMS could cost the Department of Nursing time, money, staffing, and materiel.

This research project examines the current organizational structure in Air Force medical facilities and weighs its importance as it relates to the Air Force Nurse Corps. The following is the problem statement under consideration:

> Is there a significant difference in command and control, leadership/management effectiveness, and job satisfaction/dissatisfaction in Air Force medical facilities where the Chief Nurse (SGHN/SGN) works directly for the Hospital Commander (SG) in comparison to the Chief, Hospital Services (SGH)?

This study will examine the feelings and perceptions of the 123

senior nurses currently functioning as Chief Nurses. It attempts to summarize the effectiveness of the current organizational structure in comparison to a structure where the Chief Nurse works directly for the Hospital Commander. The hypothesis is: Senior Air Force Nurses are currently experiencing difficulties with the differences between chain of command and lines of authority within Air Force medical facilities. Due to time constraints, the focus of this study is limited strictly to Nursing and the Air Force Nurse Corps. This project's sponsor, Brigadier General Schimmenti, Chief, Air Force Nurse Corps, is aware of the project's focus. Studies on additional topics related to organizational structure are currently under consideration by the Air Force Nurse Corps.

This chapter provides an overview of the current situation within the Air Force, reviews pertinent definitions, and offers a short history of the nursing profession. Chapter Two, Literature Review, will discuss current civilian writings relating to organizational structure and charts. Additionally, it offers current guidance from HQ USAF/SG and SGN regarding their goals and review a similar study done in 1982. Chapter Three is a review of the project design, the survey package and questions asked. Chapter Four discusses the survey results and trends. Finally, Chapter Five offers recommendations formulated from the data received from the field.

OVERVIEW

The Air Force Nurse Corps (AFNC) currently operates within the executive management team in 123 medical treatment facilities throughout the world. Their responsibilities are discussed in AFR 168-4, the Joint Commission on Accreditation of Hospitals (JCAH) Manuals, the American Nurses' Association (ANA) licensing criteria, and in their respective state licensure bureau's Nurse Practice Act, to name a few. Senior nurses currently functioning as Chief Nurses are responsible for over 13,000 professional and para-professional military health care providers. Additionally, they supervise and evaluate U.S. civilian and foreign national civilians in the roles of registered nurses (RNs), licensed practical nurses (LPNs), ambulance drivers, and American Red Cross volunteers. These Chief Nurses are legally accountable 24 hours a day, seven days a week for the care and safety of patients occupying close to 5000 hospital beds. Additionally, those patients seen daily in ever Out-Patient Clinic, Emergency Room, Air Transportable Hospital (ATH), Dispensary, and Aeromedical Staging Facility (ASF) worldwide fall within the realm of the Chief Nurse's management. Continuing professional education, On-The-Job-Training (OJT) programs, and clinical documentation also fall to the Chief Nurse for command and

control. AFR 168-4 lists other responsibilities of the Chief Nurse: 1) establish, coordinate, implement, and evaluate all nursing policies and procedures; 2) assign professional and technical personnel to nursing activities, based on skill assessment; 3) maintain liaison with community groups, civilian organizations, and educational agencies; 4) maintain continuous liaison with professional and administrative sections; 5) develop and interpret budget, manpower requirements, capabilities and functions of Nursing Service; and, 6) provide representatives on MTF committees which impact on Nursing Services, the patient's environment, or nursing personnel (12:3-12). Air Force Chief Nurses, by regulation and law, are accountable for a wide range of duties and responsibilities. Are all senior Nurse Corps personnel Chief Nurses? If not, how do they get this prestigious title and position?

All nurses currently filling Chief Nurse/Director, Nursing Service positions were selected during the annual Chief Nurse Selection Board under the direction of the Nurse Assignment Branch at AFMPC, San Antonio, Texas. This board, consisting of Chief Nurse representatives from the 12 major commands, review, not only new Chief Nurse applicants, but also incumbent Chief Nurses for future leadership roles. The board members review military records for job diversity, Professional Military Education (PME), level of education, management/leadership experience, and job performance. Additionally, recommendations from base and command agencies are required for those nurses under consideration. If this selection process is not stringent enough, all Chief Nurses must be approved and accepted by the DBMS at their next assignment. This process ensures Air Force medical facilities receive the highest quality professionals for the Chief Nurse position.

If the Nurse Corps is so conscientious in its selection of their senior leaders and managers, and if standards for the nursing profession state the Chief Nurse has ultimate accountability and responsibility for the quantity and quality of nursing care provided in the health care facility, then should Air Force Chief Nurses be held accountable to a physician intermediary, rather than to the Commander (16:2)? The Air Force and its views on the organizational position of Chief Nurses often place unnecessary stress on professional relationships requiring cooperation and coordination to complete the ultimate mission - quality patient care. Team work and communication are required to deliver the type of patient care the Air Force medical community prides itself in giving. To achieve this goal, all the key team members must be on equal standing. This would ensure unhampered lateral commmunication and teaching, so vital in our day-to-day operations. If one member feels out of place, for whatever reason, tensions rise and mission

accomplishment may suffer.

The Chief Nurse is often denied the authority needed to get the job done. Why? Because, the current organizational structure, as set up in AFR 168-4, places the Chief Nurse in a supervisory position below the other hospital Departmental Chiefs. The Chief Nurse, working for the Chief, Hospital Services may lose, simply because of the system's inconsistencies, some credibility and decision making authority. Additionally, the SGH, a physician, is often called upon to mediate between nursing and medical services on management issues. In an already stressful environment, these additional irritants are counter-productive. Irritants, however, can be tolerated if the end result is acceptable to all parties and no one feels compromised. This, unfortunately, is not always the case.

Nurses are required to participate in continuing education programs stressing management and leadership principles from the time they enter the Air Force. This, however, is not the first time this information is addressed in their educational process. The Nursing Process, Problem Solving, and decision making skills are studied in a vast majority of Baccalaureate Nursing programs. Once on active duty, Professional Military Education is required for promotions and is prerequisite for some special duty assignments. JCAH, the AFNC, and over 50% of all state licensing agencies require nurses to participate in annual continuing education. The Inspector General (IG) incorportated these requirements in their Health Services Management Inspection (HSMI) checklists and they specifically address the requirements for annual leadership and middle-management seminars (11:8-4). So, by the time nurses reach command positions, their professional educational background includes, at a minimum: Squadron Officer's School, Nursing Service Management, Air Command and Staff College, and one or more upper-level management seminars. These courses are critical for promotion and jobs requiring management and leadership skills. Nursing Service stresses the need to educate its people before placing them in roles where specialized training and skills are required. This preliminary training eases the transition from worker to manager and improves the patient care delivered throughout the medical facility. Physicians, however, are not offered the same educational programs as nurses, especially when it comes to management/leadership education.

Management training programs geared specifically to physician and hospital management are frequently not available to the medical staff, including the Chief of Hospital Services. Fortunately, for the military patient population, the physicians'

educational focus is on medical, patient care skills. Unfortunately, for those he supervises, his paperwork skills are often lacking. The SGH is a product of a system which rewards the numbers of patients seen and often discounts the amount of time needed to complete support work. There is little incentive for physicians to "get smart" when it comes to regulations and paper pushing. Frequently, SGH is a part-time position, especially in smaller facilities. So, in addition to all the administrative duties inherent with the SGH role, the physician must also see a quota of patients. Anyone who has had an additional duty knows how difficult it is to juggle two jobs at once. At times one of those areas must suffer, and it is most frequently the additional duty. One can not fault the SGH for putting patient care in the forefront of paperwork. However, Nursing, a section under SGH's dual responsibility hat, often finds its distribution and job taskings buried at the bottom of SGH's in-basket. An Air Force Chief Nurse responding to the author's survey states, "My SGH is brand new in his job and is still learning the ropes. Part of my job is to help him learn to be an effective SGH and to do staff work for him." This is often the rule and not the exception in many MTFs. The Chief Nurse accepts "the monkey" because it facilitates mission completion. A recent interim message change to AFR 168-4, Chapter 3, Para 3-22, "Reporting Official for Chief Nurse," dealing with USAFE/SG policy states, "These positions (SGH) are training experiences for future physician executives (Commanders). These future executives must be exposed at the earliest phase of their administrative training to all aspects of hospital management." This message also addressed the across-the-board recision of current waivers granted placing Chief Nurses under SG instead of SGH IAW AFR 168-4, 3-22, b (1), (2), and (3) (Appendix 1-3). This training is frequently provided by nursing. Chief Nurses, the ratees, are training their professional counterparts from the physician sector, their raters. One respondent to the author's survey offered an opinion on this particular situation, "Young SGH's are not usually as willing to learn from a subordinate as they are from a peer." Anyone functioning as an instructor knows there is often friction when a younger, subordinate, especially one from a different career field, must teach an older, ranking individual a task which the senior member should already know. The feeling of ineptness in situations, as above, frequently results in ineffectiveness. The perception of inadequacy, if one believes this paper's respondents, hampers the efficiency of the system.

Chief Nurses frequently function in a four letter Functional Address Symbol (FAS), SGHN. AFR 10-6, "Air Force Functional Address System," lists the accepted Air Force FAS for the base level MTF. Thirteen two and three letter symbols are listed in all. They cover the entire gamut of upper-level managers with one exception--Nursing (10:6). Nursing is not even

mentioned because it falls under the direct supervision of the Chief, Hospital Services. For this reason, nursing carries a FAS of SGHN instead of SGN, which would occur if Nursing was categorized as a lateral Departmental Chief. The current situation is unwieldy at best. USAFE and TAC, as described by some of the Chief Nurse respondents, follow guidelines which conflict with those set up in AFR 168-4. Some nurses are working for SGH but are answering to SG and vice versa. These inconsistencies and differences between reality and prescribed guidelines could result in management difficulties within the medical setting. These difficulties might impact adversly on the Hospital's ability to deliver quality patient care. A discussion, dealing with a possible historical reason for our current plight, will follow a review of pertinent organizational definitions.

DEFINITIONS

1) Director of Base Medical Services (DBMS)/Hospital Commander (SG): health care facility chief executive officer, usually a physician, responsible for supervising and directing the use of base medical resources (12:3-1 - 3-2).

2) Administrator (SGA): a Medical Service Corps (MSC) officer, performing in an executive capacity, responsible to the Commander for administrative support. This individual is not a health care provider. Directs all health services administration and support functions including Patient Affairs, personnel and administration, medical logistics, and resource management programs (12:3-4).

3) Chief, Hospital/Clinical Services (SGH): a physician, who directs all subordinate services toward the highest standards of professional practice and ethics within established operating policies. Provides professional staff support for inpatient and outpatient units and clinics (12:3-8).

4) Chief Nurse/Director of Nursing Services (CN/SGHN): a professional nurse who is responsible for the management of nursing services. The Department of Nursing supports all areas involved in the care and treatment of patients (12:3-12).

5) Medical Treatment Facility (MTF): any fixed medical facility having as its primary purpose the provision of care to patients. Sizes range from small out-patient clinics to a 1000 bed medical center (16:4).

HISTORY OF NURSING

Nurses have been around as long as patients have. But, what exactly is "nursing"? In 1958 Virginia Henderson described nursing as,

> The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge. And to do this in such a way as to help him gain independence as rapidly as possible (2:5).

The above definition gives a pretty good picture of what's expected of nurses in their duties. However, there are still barriers preventing nurses' progress to more expansive roles. Muriel Uprichard points out nursing has three heritages from the past which tend to inhibit progress. She identifies these as, "the folk image of the nurse brought forward from primative times, the religious image of the nurse inherited from the medieval period, and the servant image of the nurse created by the Protestant-capitalist ethic of the 16th to the 19th century (2:12)." Ellis and Hartley offer a more in-depth review of the past. Historical review does not mention nursing, as we know it today, until mid-nineteenth century England. Prior to this, medicine men drove away evil spirits using "magic". As medical science developed, auxillary personnel were needed to tend to the sick. In India, 1200 B.C., nursing care was carried out entirely by men. During Greek and Roman times many physicians are acknowledged, but nurses per se are not mentioned. With the emergence of Christianity, the history of modern nursing began. Young, single women practiced "works of mercy" in hospital-like settings and at the homes of the ill. The church played a key role in the development of nursing practice and tradition. Today the nursing profession still practices many of these time honored traditions. The role of the chaste angel of mercy is still thought, by many, to be an acceptable role. However, nurses are often stuck in the rut brought about by the servant image role. The Reformation began in 1517 and women were deemed subordinate to men. Nursing was considered an undesirable domestic chore - a nurse was a menial servant. It was not until the 1630's nursing was, once again, taken over by the church and regained it's notoriety in Europe. Change started earlier in the American continent. The first medical school in America was the University of Mexico founded in 1578. In 1641, the Ursuline Sisters of Quebec tried to organize the first training for nurses on this continent. At the same time, Europe was making up for lost time and medical advances abounded; nurses were making their

mark (2:25-26). During this time the most significant person in the history of nursing emerged--Florence Nightingale. She selflessly served the ill during the Crimean War and in 1860 established a school of nursing. Many of Florence Nightingale's original principles of nursing are still applicable today. She believed and practiced nursing as a profession:

> Nurses should spend their time caring for the patient, not cleaning; that nurses must continue learning throughout their lifetime and not become "stagnant"; that nurses should be intelligent and should use that intelligence to improve the conditions of the patient; and that nursing leaders should have social standing (2:27).

David Mechanic lists four factors that emerge from history which may influence nursing today:

1. Nursing developed as an ancillary occupation supportive to physicians.

2. Nursing is primarily an institution-based occupation.

3. Nursing is a predominately female occupation.

4. The association of early nursing education with religious orders has reinforced a continuing expectation of service, dedication, and charity (6:409).

Today's nurses function in diverse roles. The media's image of nurses is oftentimes less than flattering and may be the result of their heritage. The ability to provide quality care to all patients depends on nurses selling nursing as the profession it really is. Currently, the AFNC falls short in fulfilling Florence Nightingale's concept of "social standing" as a need. Chief Nurses require the professional stature commensurate with their assigned responsibilities. Equal placement in the management structure limits departmental power-plays and fosters the team concept. Working together toward quality patient care will accomplish both the Air Force goals and individual desires. History need not repeat itself if, as professional care givers, we are willing to work together to ensure all executive staff members receive the authority necessary to fulfill their varied responsibilities.

Chapter Two

LITERATURE REVIEW

THE LIBRARY KNOWS

Chapter One stated the problem: organizational inequality; historical background images; and, established social mores still influence nursing's current responsibility/authority struggle. The role of the modern nurse has been discussed in books, magazines, seminars, doctoral dissertations, and coffee shops across the world. These discussions addressed male vs female role models, MD vs RN, RN vs administration, military vs civilian, good vs evil, the list is endless. In addition, nursing carries two other major roles in the hospital setting: 1) Caring role - clinical decision making on an individual patient level; and, 2) Integration role - hospital management at a unit level (6:415). Who's doing all the talking - nurses! Nurses have identified the problem, they've beaten it to death, and sometimes they've convinced someone, other than a nurse, to listen. There is some very enlightening material available, which, if taken to heart, could alleviate many of the frustrations.

Before entering the civilian sector, three Air Force specific items require review and consideration. In 1982, Olive Y. Brunner, Col, USAF, NC, completed a Doctoral Dissertation titled, "The Organizational Structure of Air Force Hospitals and It's Effect on Management of Nursing Services." After extensive research and in-the-field fact finding she reports the following:

1. Organizational placement of the DNS [Director of Nursing Service] does appear to affect the effectiveness of Nursing Services in the areas of nurse/physician interactions and safety and competence of nursing care (16:87).

2. A majority of DNS would prefer to report directly to the Commander (16:53).

3. A DNS respondent said, "The DNS should function apart from the DHS [SGH] as the Nurse Corps is distinct from the Medical Corps and should not be viewed as 'subservient' (11:91)."

Col Brunner's study revealed that nurses are unhappy and tired of being hand-maidens, and want equal representation within the medical treatment facility (11:94). On a more recent note, Lieutenant General Chesney, the Air Force Surgeon General, published an official letter, on 5 December 1985, addressing the Air Force Medical Service Priorities. There are four main priorities: 1) Readiness/Operational Support; 2) Quality of Care; 3) Management Innovation; and, 4) Patient Satisfaction (13:4). In addition, the General lists four qualities which are crucial to the effective execution of these priorities: 1) Responsibility; 2) Leadership; 3) Accountability; and, 4) Officership (13:4). The priorities and qualities are all interrelated. Priority #3, Management Innovation, is expressed as the ability to develop more effective and efficient ways of conducting a comprehensive medical program in the face of day-to-day fiscal constraints. Below are the qualifying statements after the qualities:

> All members of the Air Force Medical Service perform duties in which responsibility, leadership and accountability are inherent to some degree within the workplace. Officership pertains to the faithful discharge of duties in a position of authority within the U.S. Air Force. It includes adherence to high standards of personal conduct and integrity (13:4).

Lieutenant General Chesney's letter and it's three attachments are the framework for the operation of all Air Force Medical Service programs. Does this affect the Air Force Nurse Corps? On 15 September 1986, Brigadier General Schimmenti, Chief Nurse, USAF, NC, visited USAF Regional Medical Center, Maxwell, Maxwell AFB, Alabama. This was her initial visit to Maxwell since her appointment to Chief Nurse. The General discussed the Corps and her desires for the future. Additionally, the General said the AFNC would share the priorities and qualities developed by Lieutenant General Chesney. Nursing would not have Corps specific goals, but would support and work toward the fulfillment of the Surgeon General's priorities. The AFNC would not alienate themselves from the Officer Corps or the Medical Service Corps. The mission was paramount! Brigadier General Schimmenti believes in total support of the teamwork concept for the good of a common goal. How can the health care team work together most efficiently to improve quality patient care and enhance executive management cohesiveness? The majority of this project's

respondents feel placing the Department of Nursing on equal footing with the other Department Chiefs would be an initial step toward problem resolution.

In reality, the three individuals mentioned above really tell the entire story. Col Brunner identified the problem in 1982. Lieutenant General Chesney and Brigadier General Schimmenti want innovative management and expect their executive team to be accountable leaders and officers. The priorities and qualities are the solution. The results of this study will add, to the above, the personal feelings and professional expertise of the Corps' current Chief Nurses. However, before the author limits the discussion to a strictly Air Force Nurse Corps perspective, a review of the current civilian literature is required.

Lieber, Levine, and Dervitz in their book, Management Principles for Health Professionals, define the organizational chart as a diagrammatic form depicting the five following institutional aspects: major departmental functions; relationships between functions/departments; channels of supervision; lines of authority/communication; and, positions within departments. Effective and current organizational charts are excellent guides and useful mangerial audit tools. The manager, through review of what is and what ought to be can spot obvious discrepancies and inconsistencies adversely affecting job quality. However, as with all tools, there are limitations. Four are discussed. All four are certainly applicable to this study and deal with: formal vs informal lines of communication/ authority; chart obsolesence; confusion between authority relationships and status; and, the need for accurate, timely support information, e.g. job descriptions (4:85-86).

The above information addresses some timely views concerning the use and abuse of organizational charts. The Air Force does not usually offer this information, in a succinct, logical format to its new physician managers. Nurses, on the other hand, receive this information and more in Nursing Service Management (NSM). NSM students draw up organizational charts with corresponding job descriptions, similar to the ones required by the IG. The concepts are well understood by the majority of nurses with more than five years of active duty, and those functioning in management positions. The problems do not appear to lie with nurses understanding nursing. The trouble seems to surface when non-nursing personnel supervise nursing. Maybe the problem stems from poor communication skills and the inability to discuss organizational representation and organizational placement clearly. "An organizational chart is a drawing showing how the parts of an organization are linked. It depicts the formal organizational relationships, areas of responsibility,

persons to whom one is accountable, and channels of communication (5:65)." The crux of the problem could envelop the responsibility section of the above definition. Nursing seems to have a vast amount of responsibility: patient care; documentation; training; education; counseling; and, evaluation, to name a few. Nurses spend more time with the patients than anyone else and are the first line of defense if something goes wrong. The Air Force delegates the authority to make the quick, life-saving decisions required to get the job done. From the author's experience in Air Force nursing, the authority and responsibility to stabilize the critically ill patient until the physician arrives is inherent with the job. The ability and necessity to plan ahead and to be ready for potential changes in treatment modalities is expected. Additionally, readiness for any contingency is the key to successful patient care. These expectations and requirements for foresight do not change when senior nurse officers reach administrative positions. What does seem to change is the amount of authority the Commanders delegate to their nurse managers.

Is there a difference between the management of patients and the management of those who care for these patients? As young Lieutenants and Captains, staff nurses are placed in difficult and stress producing situations commensurate with caring for critically ill people during all hours of the day and night. Once nurses reach managerial level jobs they are often restricted in their ability to function without direct supervision. The Department of Nursing is still expected to have meeting minutes ready, but current manpower authorizations do not support fulltime secretarial positions. The Chief Nurse still has to provide trained medical personnel to provide qualified medical support at base sporting events, but is not always included in the planning for these staffing requirements. Promotions are gained using similar criteria, e.g. PME, job diversity, joint tours, educational level, as our non-nurse peers, but because of the subordinate position nurses hold in the hospital organizational structure, nursing personnel are not always afforded the opportunity for higher command Officer Effectiveness Rating (OER) endorsements. These problems and feelings may seem petty to those not affected. However, these are the feelings of the professional nurses currently responsible for the welfare and lives of patients and staff. Douglass and Bevis in their book, Nursing Management and Leadership in Action, offer a predictive principle in dealing with organizational structure. They claim, "Creation of an organizational system compatible with the philosophy, conceptual framework, and goals of the organization provides the means for accomplishment of purpose (1:49)." Seth Goldsmith says it another way, "Organizational structure exists to facilitate decision making and to provide a road map to an organization. It is a means of effective operation (3:154)." If the two sources listed above are logical, then implementing these ideas should provide

positive results within the Air Force medical community. The purpose and operation of the Air Force medical system is to serve the health needs of our military community; to support the mission. An effective organizational system, coupled with teamwork, coordination, communication, sharing and caring will result in mission accomplishment and improved quality of patient care.

Chapter Three

METHODOLOGY

WHAT HAPPENED?

The goal of this project was to gather, not only hard data, such as current organizational charts and actual office symbols, but also perceptions of incumbent Air Force Chief Nurses on the effectiveness of their current organizational situation. The situation as stated in Chapter One and supported in Chapter Two, is the obvious gap between responsibility and authority within the hospital system. The Department of Nursing normally has the largest department in terms of personnel, patients cared for, and budget. Nursing has far more responsibility than say the Plant Manager, SGG, who's job it is to maintain building safety. However, the Plant Manager, on the current Air Force hospital organizational structure, shares the same authority position as the Chief, Hospital Services, and could precede the Chief Nurse in the Hospital's chain of command. The hypothesis tested is:

> Senior Air Force Nurses are currently experiencing difficulties with the differences between Chain of Command and Lines of Authority within Air Force medical facilities.

The survey/questionnaire, USAF SCN 86-129, is a combination of eleven closed and open-ended questions dealing with the hospital organizational structure, its effectiveness, and the most recent HSMI results. It allows the respondents to offer their ideas for possible alternatives/changes to their present situation. The survey package (Appendices 2-1, 2-2, 2-3, and 2-4) was sent to 123 senior nurses currently functioning as Chief Nurses in Air Force medical treatment facilities worldwide. They were sent 15 October 1985 from Maxwell AFB, Alabama with a return deadline of 20 December 1986. Self-addressed, stamped return envelopes were included for the respondents. As of 20 December 1986, 91 of the 123 surveys were returned; 74%. Copies of the sanitized organizational charts attached to the answer sheets were separated upon

publication of this paper, all surveys and any attachments will be destroyed.

Questions 1 through 8 required factual answers dealing with facility size, location, current office symbol of the Chief Nurse, Corps designation of the Hospital Commander and the Hospital Administrator, number of nursing service personnel supervised, and results of the most recent HSMI for SG, SGH, and SGHN/SGN. These answers did not offer any room for speculation, creativity, or candor on the part of the respondent.

Questions 9 through 11 gave Chief Nurses the opportunity to "tell all". Opinions, suggestions, and words-of-wisdom were graciously and thankfully accepted by the author. The factual results will appear in Chapter Four and all the written responses to questions 9 through 11 will appear in Appendices 3-1, 3-2, and 3-3. These results are the culmination of years of nursing and administrative practice and expertise. The Chief Nurses in today's Air Force want to do their best and are willing to work with the system to make it happen.

Chapter Four reports the results obtained from the survey. The data will be grouped as stated above. Conclusions and recommendations drawn from this data will be presented in Chapter Five.

Chapter Four

RESULTS

QUESTIONS 1 THROUGH 8

CONUS MEDICAL FACILITIES

	Clinic	Hospital	Rgn Hospital	MedCen
Total:	16	52	8	6
Responses:	12	36	8	5
Nurses:	1 - 4	10 - 56	53 - 109	142 - 628
Techs:	10 - 34	42 - 130	90 - 173	156 - 710
Office Sym:				
SGHN	4	20	7	5
SGN	8	16	1	0
SG Corps:				
MC	7	34	8	5
DC	1	1	0	0
MSC	4	1	0	0
SGA Corps:				
MSC	11	33	8	5
BSC	1	3	0	0

	Clinic	Hospital	Rgn Hospital	MedCen
HSMI Results:				
SG				
Outstd	0	1	1	0
Excel	2	7	1	2
Sat	10	25	5	3
Marg	0	0	0	0
Unsat	0	0	0	0
SGH				
Outstd	0	1	0	0
Excel	3	5	2	2
Sat	9	25	4	3
Marg	0	1	1	0
Unsat	0	1	0	0
SGHN/SGN				
Outstd	0	1	0	0
Excel	4	16	4	1
Sat	7	16	3	4
Marg	1	0	0	0
Unsat	0	0	0	0

QUESTIONS 9 THROUGH 11

9. What Organizational Chart/System are you currently functioning under?

a. Is it effective? YES - 45 NO - 16

(SGN - 24 SGHN - 21) (SGN - 0 SGHN - 16)

10. Do you think the Air Force Nurse Corps would benefit from a standardized organizational structure within our medical facilities?

YES - 50 NO - 11

11. If you function as SGHN, do you feel your SGH has the time, training, and desire to act in the best interest of the Department of Nursing?

YES - 11 NO - 33

N/A - 17

OVERSEAS MEDICAL FACILITIES

	Clinic	Hospital	Rgn Hospital	MedCen
Total:	22	14	2	2
Responses:	17	8	2	2
Nurses:	1 - 8	4 - 35	71 - 75	116 - 122
Techs:	6 - 35	28 - 49	110 - 132	161 - 164
Office Sym:				
SGHN	12	5	2	2
SGN	5	3	0	0
SG Corps:				
MC	9	8	2	2
DC	0	0	0	0
MSC	7	1	0	0
SGA Corps:				
MSC	16	7	2	2
BSC	1	1	0	0
HSMI Results:				
SG				
Outstd	0	0	0	0
Excel	4	2	1	2
Sat	10	4	1	0
Marg	0	0	0	0

	Clinic	Hospital	Rgn Hospital	MedCen
SGH				
Outstd	1	0	0	0
Excel	4	4	1	1
Sat	11	3	1	1
Marg	0	0	0	0
Unsat	0	0	0	0
SGHN/SGN				
Outstd	0	0	0	0
Excel	8	6	1	1
Sat	8	1	1	1
Marg	0	0	0	0
Unsat	0	0	0	0

QUESTIONS 9 THROUGH 11

9. What Organizational Chart/System are you currently functioning under?

a. Is it effective? YES - 20 NO - 9

(SGN - 8 SGHN - 10) (SGN - 0 SGHN - 11)

10. Do you think the Air Force Nurse Corps would benefit from a standardized organizational structure within our medical facilities?

YES - 20 NO - 9

11. If you function as SGHN, do you feel your SGH has the time, training, and desire to act in the best interest of the Department of Nursing?

YES - 3 NO - 22

N/A - 4

PUTTING IT ALL TOGETHER

All answers received were reviewed and categorized. Answers were not altered and appear as originally written. 90 of 91 respondents answered questions 1 through 7, without exception. Questions 8 through 11 were answered by the majority of the respondents. Consequently, all categories will not total 91. One respondent represented an overseas Aid Station. This individual functions directly under the Wing Commander and this data did not "fit" this study. The numbers of Air Force facilities by category, i.e., Clinic, Hospital, Regional Hospital, and Medical Center, were drawn from the most current AFNC Chief Nurse directory and the 1 April 1986 edition of "AFSCs Utilized at USAF Hospitals, Clinics, and Flying Units," prepared by AFMPC NC Career Management Branch.

What do the results mean? Do they answer the question proposed in Chapter One? Do the responses support the hypothesis under consideration? First, let's review the question and, if appropriate, match answers to it. Second, a review of the hypothesis and a decision to support or not support it according to the survey results. Finally, what additional information was extracted from the results and will it impact the AFNC and how nurses function within the current medical system?

THE QUESTION

The proposed question was:

> Is there a significant difference in command and control, leadership/management effectiveness, and job satisfaction/dissatisfaction in Air Force medical facilities where the Chief Nurse works directly for the Hospital Commander in comparison to the Chief, Hospital Services?

The author will handle each element individually and offer feasible explanations using the data received and reviewed from the 91 respondents.

1) Command and Control: 99% of the respondents want to work for the Hospital Commander. They feel their credibility and authority/responsibility standings improve under this type of organizational set-up. 30% of the Conus respondents and 31% of the Overseas respondents were unhappy with their current

organizational structure. These numbers represent those Chief Nurses who currently work for the Chief, Hospital Services, not those currently working directly for the Hospital Commander. Additionally, 75% of the Conus respondents and 88% of the Overseas respondents felt their current Chief, Hospital Services lacked either time, training, or desire to adequately represent the Department of Nursing in hospital matters.

2) Leadership/Management Effectiveness: Only 1% of the respondents received less than a Satisfactory rating on their most recent HSMI. A feasible conclusion; regardless of who the Chief Nurse works for, the atmosphere in the work area, or their personal feelings, the job is getting done and meeting the standards of the IG. However, there is more to quality nursing care and quality leadership techniques than passing an inspection. The Nurse Corps has required all its nurses to maintain current professional nursing licenses. By regulation, nurses must also complete 30 hours of Continuing Nursing Education to maintain Air Force Nurse Corps standards. Additionally, nursing has been active in Quality Assurance programs and peer review, even before Dr. William Mayer's findings in 1983-1985 (7:3; 8:9; 9:8; 14:13; 15:2). Nursing has much to share with the other medical specialities and this information can only help our patients and the hospital's public relations image.

3) Job Satisfaction/Dissatisfaction: The majority of the respondents voiced concern and discontent regarding their current job situation. Examples of a few respondent answers; "I feel very stongly about this issue.", "The nursing chain is effective.", "We are professionals.", [Work for SG] Absolutely - then personality and local preference does not play a part.", and "[SGH] Desires good working relations but does not have backing or desire to side with nurses against physicians on any issue." These represent only a small number of the actual respondent answers. However, they do represent a majority of the feelings being presented in the other answers. The Air Force has an active Project KEEP program and wants to retain an active force of highly qualified professionals. So far nursing has not lost many of its senior personnel to the civilian community, like the Air Force is seeing with the pilots and navigators. However, this may one day become a reality as we see a civilian nursing shortage and the beginning of higher monetary and personnel incentive packages. As a former Nursing Education Coordinator, the author is aware of the time and money spent to train and orient new nursing service personnel. If the Air Force, by offering its senior nurse corps executives an equal footing in the hospital's management force, can maintain this group of highly trained professionals, without any monetary or extra benefit packages, can they afford not to make the change?

THE HYPOTHESIS

As stated in Chapter One the hypothesis to be tested is:

> Senior Air Force Nurses are currently experiencing difficulties with the differences between Chain of Command and Lines of Authority within Air Force medical facilities.

There seems to be a great deal of conflict occurring in the field. USAFE/SG, in a recent IMC to AFR 168-4, says all nurses will work for SGH, regardless of rank inversion or training. TAC/SG, as written by one respondent, says all nurses will work directly for SG. Additionally, nurses claim they are working for SGH on paper, but SG wants them to refer all problems and information to them, SG, directly. Another respondent mentions working around the SGH to get the job done. All these options add confusion to a system, the hospital, where precision and continuity are critical to timely patient care. Hence, the author believes the data supports the aforementioned hypothesis.

WHAT ELSE?

What other comments and conclusions can be drawn from this study:

1. All nurses currently functioning in an SGN role are happy with their organizational situation and would not like it to change.

2. Some nurses with a FAS of SGHN are actually working for SG (not all mention waiver approval), but have not changed their office symbol to SGN.

3. Only 1 of the 91 respondents did not request/support an across-the-board change to an AFNC/SGN organizational position. This individual came from a Medical Center. The respondent felt the Chief Nurse's position as a division chief working for SGH, along with 4 other divisions, was the most advantageous to the Department oF Nursing. Medical Centers are authorized a full-time SGH, according to manpower standards, and these indivduals are normally highly trained and motivated in their support of the auxillary services functioning under them.

This Chapter has compiled and reviewed the data and has offered conclusions drawn from the information received. Chapter Five will now take these conclusions and offer suggested recommendations for action. Additionally, as mentioned earlier, this study was focused strictly on Air Force Nurses. There are any number of groups to study which also impact on the Hospital setting and the organization's ability to get the job done. The author will offer three suggested studies for future investigation.

Chapter Five

RECOMMENDATIONS

WHAT THE CHIEF NURSES WANT

74% of the Air Force Chief Nurses actively participated in this study on their current hospital organizational structure. The responses ranged in the author's judgment, from condescending to livid in reaction to working for SGH, not with SGH and for SG. 99% of the respondents want to be equal members on the hospital's executive management team. Their responses are listed in Appendice 3-1, 3-2, and 3-3 and have been referenced numerous times in the body of this paper.

The author recommends to HQ USAF/SGN the following based on the data received from USAF Survey SCN 86-129:

1. Amend AFR 168-4, to reflect all MTF Chief Nurses as SGN, working directly for SG.

2. Amend AFR 10-6, to inlcude SGN as an approved three-letter FAS in attachment 1, page 6, under the heading Surgeon General/Hospital Commander.

3. Delete from AFR 168-4, section 3-22, b (1), (2), and (3). This addresses waiver criteria. See Appendix 1-3.

4. Amend AFR 168-4, Chart 3-1, by removing the exception rule dealing with the Department of Nursing's position on the organizational chart.

5. Amend AFR 168-4, Chart 3-2. Remove Nursing from under the direct supervision of Hospital Services.

6. Allow for exceptions to the above organizational structure change with the approval of ALL parties involved.

What might be the impact of these changes if they were insituted? First, the responsibility-authority gap would be narrowed and/or eliminated. Nurses would, not only be held accountable for their actions, no change from the present, but would also be able to make the decisions initiating those actions. Second, nurses would be monitoring nurses. There would be limited intervention from non-nursing professionals who may not understand the way nurses are doing business. Third, nurses could take credit for their extensive breadth of job, management, and leadership expertise. Playing second fiddle would be obsolete. Fourth, nursing would take its rightful place on the executive management team as an equal member. This brings with it more Wing exposure, a better opportunity for higher level OER endorsements (an issue mentioned by many respondents), and also a feeling of equality among all professional peers. Additionally, it removes many communication barriers and allows for a more conducive atmosphere for sharing ideas and knowledge. Fifth, the chance for conflict of interest between services could be eliminated in the day-to-day MTF and nursing operations. Lastly, and a subject near and dear to those nurses who have spent long hours at the word processor getting ready for an IG, Nursing would qualify for a secretary. With a three-letter office symbol, SGN, professional needs change, according to the manpower documents, and more qualified secretarial support is the result.

These are the results, the recommendations for action, and possible consequences of these actions. However, this study was not all-inclusive and there are many other avenues requiring exploration by nursing professionals. The author suggests three additional areas for further study below. These issues currently affect the way Air Force nurses do their jobs. Again, these suggested topics are by no means exhaustive. Nurses are limited only by their imaginations.

1. The nurses who function in non-traditional nursing roles, i.e. Operating Room, Anesthesia, Nurse Practitioner, do not fall within the authority lines of the Department of Nursing. They do, however, still fall within those responsibility lines. Frequently, these nurses are excluded, because of distribution policies, schedule differences, and communication difficulties, from the day-to-day activities of the Department of Nursing. They often have trouble keeping up with policy changes, new requirements, career opportunities, school slots, etc. It would be interesting to canvas these nursing personnel for their feeling and suggestions on how to fix it if in fact it is broken.

2. Within the last couple of years a Hospital Executive Managers course has been in operation at the School of Health Care Sciences at Sheppard AFB, Texas. It was developed to train first time hospital executive team members; SG, SGA, SGH, and SGN, on cooperation, coordination, and communication between the Corps. It stresses a team concept in the management arena. It would be interesting to compare a group(s) with this training opportunity to a group(s) without the opportunity to learn these management skills prior to their assignment. Are there changes in the HSMI results? Are there fewer patient complaints? Are there changes in personnel retainability?

3. How do the Hospital Commander´ and Chiefs, Hospital Services view Nursing? Do they feel the current system is adequate? Together, are the services getting the job done? Do these senior leaders realize Nursings feeling of discontent? Do they think the manpower standards correctly mirror the work being done? Can the Department of Nursing help reduce the stress level of these professionals, thus improving their ability to care for patients?

The Air Force Nurse Corps is growing and changing with the times. A cadre of highly trained and motivated professionals, nurses work in every conceivable medical specialty. Nurses are proud to serve and want to do the best job possible. Nurses want to be recognized for their many contributions made, not only in the civilian community, but also in the Air Force´s medical system. The Chief Nurses of the United States Air Force have spoken. Is anyone listening?

BIBLIOGRAPHY

A. REFERENCES CITED

Books

1. Douglass, Laura Mae, and Em Olivia Bevis. Nursing Management and Leadership in Action. St Louis, MO: The C.V. Mosby Co., 1983.

2. Ellis, Janice R. and Celia L. Hartley. Nursing in Today's World: Challenges, Issues, and Trends. Philadelphia: J.B. Lippincott Co., 1984.

3. Goldsmith, Seth B. Health Care Management: A Contempory Perspective. MD: Aspen Publ., 1981.

4. Liebler, Joan G., Ruth Ellen Levine, and Hyman L. Dervity. Management Principles for Health Professionals. MD: Apsen Publ., 1984.

5. Marriner, Ann. Guide to Nursing Management. St Louis, MO: The C.V. Mosby Co., 1984.

6. Mechanic, David (ed.). Handbook of Health, Health Care, and the Health Professionals. NY: The Free Press, 1983.

Articles and Periodicals

7. Editorial. "Surgeon General Orders Medical Quality Control." Air Force Times, 45 Year, No. 43 (13 May 1985) p 3.

8. Mayer, William E. "DOD to Require Licensing of Health Professionals." Air Force Times, 44 Year, No. 38 (9 April 1984), p 9.

9. Maze, Rick. "DOD May Require Medical Licenses." Air Force Times, 45 Year, No. 38 (8 April 1985), p 8.

Official Documents

10. Air Force Regulation 10-6. "Air Force Functional Address System," 10 October 1985.

11. Air Force Regulation 123-1. "The Inspection System," 12 November 1985.

12. Air Force Regulation 168-4 (C-1). "Administration of Medical Activities," 11 July 1980.

13. HQ USAF/SG. Letter: Air Force Medical Service Priorities. Bolling AFB, MD: 5 December 1985.

14. TIG Brief. "QA/RM: Patient Sensitivity," 28 May 1984, p 13.

15. TIG Brief. "Quality Care and Quality Assurance As Seen by the Medical IG," December 1984, p2.

Unpublished Materials

16. Bruner, Olive Y. "The Organizational Structure of Air Force Hospitals and Its Effect on Management of Nursing Services." Doctoral dissertation, Claremont Graduate School, 1982.

CONTINUED

B. RELATED SOURCES

Books

Alexander, Edythe L. Nursing Administration on the Hospital Health Care Systems. St Louis, MO: The C.V. Mosby Co., 1978.

Bennett, A. C. (ed.). Improving the Effectiveness of Hospital Management: A Training Manual for Managers and Supervisors in Hospitals and Other Health Care Institutions. New York: Preston Analearn, 1975.

Grippando, Gloria M. Nursing Perspectives and Issues. Albany, NY: Delmar Publ. Inc., 1983.

Heydebrand, Wolf V. The Physicians Hand: Work, Culture and Conflict in American Nursing. Philadelphia: Temple University Press, 1982.

Sheldon, Alan. Organizational Issues on Health Care Management. NY: Spectrum Publ. Inc., 1975.

Articles and Periodicals

Beyers, Marjorie. "Getting on Top of Organizational Change. Part I: Process and Development." Journal of Nursing Administration, Vol. 14, No. 10 (October 1984), pp. 32-39.

Del Bueno, Dorothy. "Power and Politics in Organizations." Nursing Outlook, Vol. 34, No. 3 (May/June 1986), pp. 124-128.

CONTINUED

Freund, Cynthia M. "Director of Nursing Effectiveness: DON and CEO Perspectives and Implications for Education." Journal of Nursing Administration, Vol. 15, No. 6 (June 1985), pp. 25-30.

APPENDICES

APPENDICES

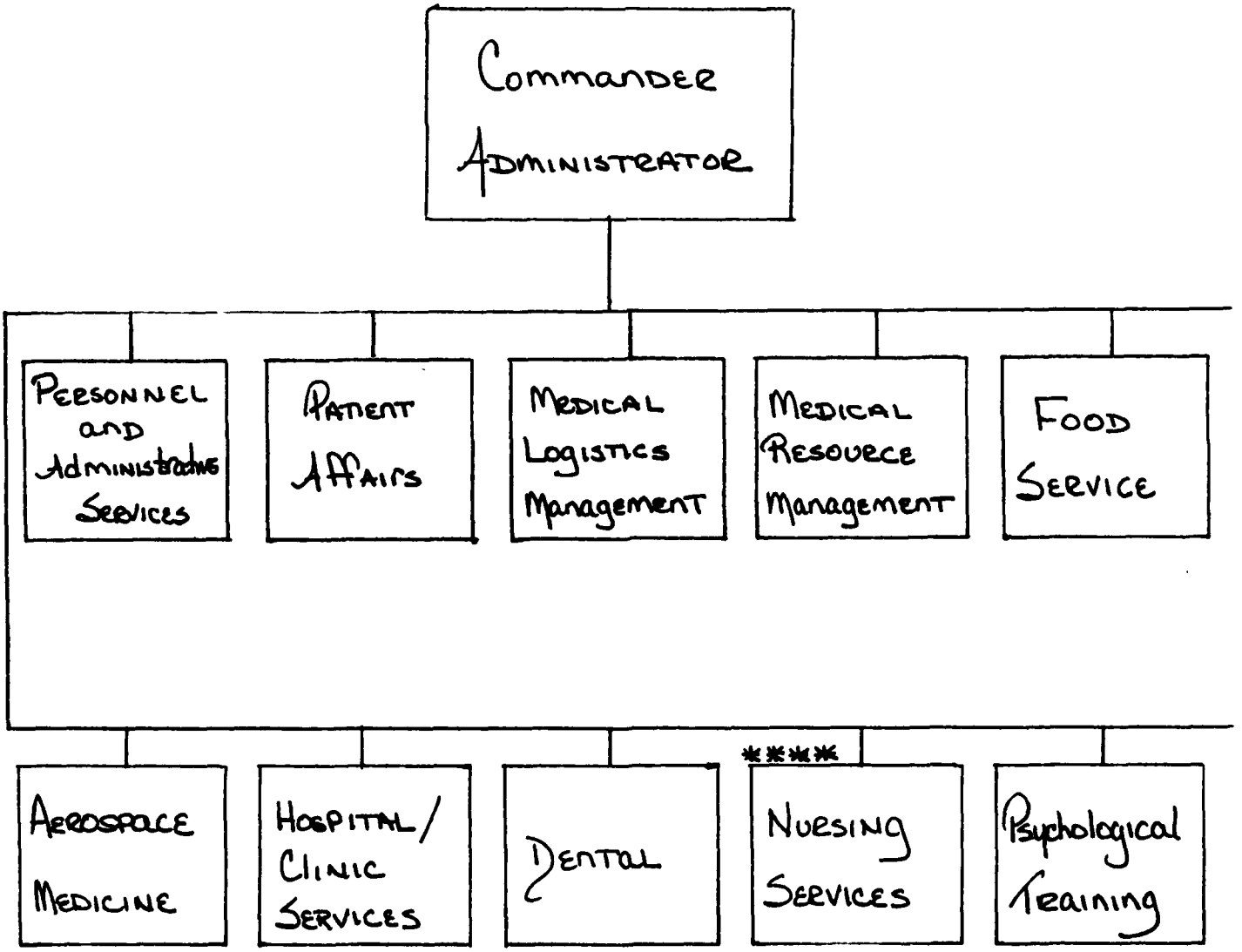
APPENDICES 1 SERIES

AIR FORCE REGULATION 168-4

APPENDIX 1-1

AFR 168-4, CHART 3-1, p 3-25

HOSPITAL/CLINIC ORGANIZATIONAL STRUCTURE

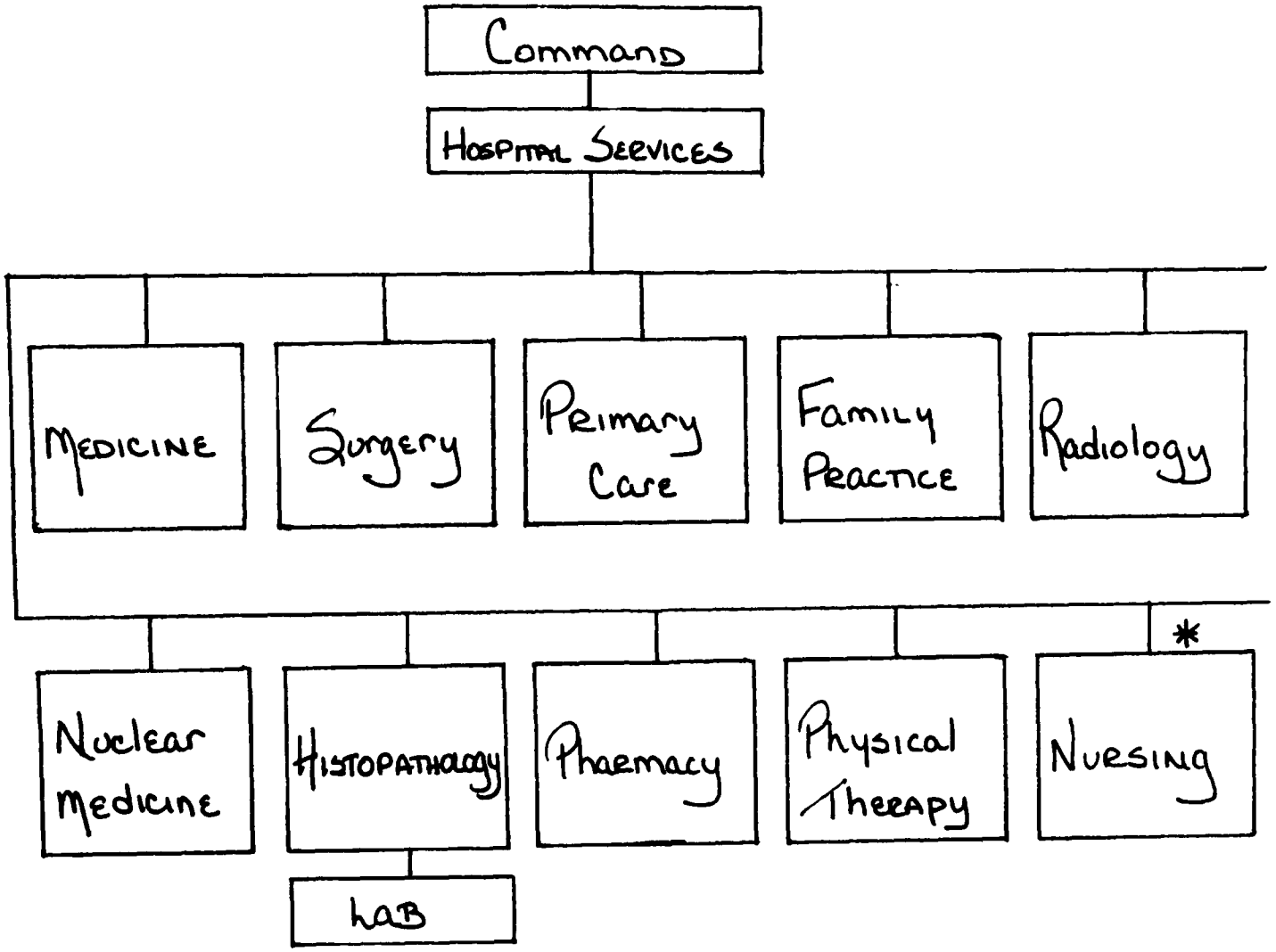


**** When approved IAW paragraph 3-22.

APPENDIX 1-2

AFR 168-4, Chart 3-2, p 3-27

ORGANIZATION -- HOSPITAL AND CLINIC SERVICES



* When approved, function may report directly to Command as shown in Chart 3-1 (paragraph 3-22).

APPENDIX 1-3

AFR 168-4, Section K - HOSPITAL SERVICES
3-22, b (1), (2), (3), p 3-8.

When, under certain conditions, it has been deemed impractical for SGH to exercise direct supervision over the CN, the supervisor and reporting official may be the DBMS. All activities of Nursing Services remain the same. Those conditions, all of which must be met are:

(1) A fulltime SGH position is not earned under the medical manpower standards (AFMS 5200) or a fulltime SGH is not assigned.

(2) The DBMS justifies the impracticality and requests the waiver from the standard organizational structure.

(3) The Command Surgeon concurs.

APPENDICES

APPENDICES 2 SERIES

THE SURVEY PACKAGE

APPENDIX 2-1

DEPARTMENT OF THE AIR FORCE
AIR UNIVERSITY
AIR COMMAND AND STAFF COLLEGE
MAXWELL AIR FORCE BASE, AL 36112-5542

REPLY TO ATTN OF: 3822 STUS - 20 (Maj Hart) 1 October 1986

SUBJECT: Air Command and Staff College Research Project

TO: All Air Force Chief Nurses

1. I am a student at Air Command and Staff College, Maxwell AFB, Alabama. The curriculum requires a research project for graduation. As a member of the Air Force Nurse Corps I want to pursue a topic of importance to our Corps. I consulted B/Gen Schimmenti and she suggested I review current medical facility organizational structures. Where does the Department of Nursing fit in to the Hospital's Chain of Command? Using data from the field, what would our recommendations be for change or continuance?

2. Attached is a short questionnaire that I ask you to complete. I have sent the questionnaire to each Chief Nurse in the Air Force and I solicit your most honest and candid responses to the survey items. Non-attribution will be practiced and the information destroyed after analysis and reporting. My project completion date is 1 February 1987, so I would appreciate your input NLT 20 December 1986. Your timely completion of the enclosed is paramount to project success. A copy of the completed project will be forwarded to B/Gen Schimmenti for review. I look forward to your ideas, suggestions, and expertise.

3. Should you have **ANY** questions, please feel free to call or write me at the following:

ACSC Duty Number: (205) 293-6794 (AUTOVON 875)
Please leave a message and I will return your call.

Home Phone Number: (205) 265- 7647 after 1800 hours.

Address: Maj Debby Hart
PSC #1 Box 5538
Maxwell Air Force Base, Alabama 36112

4. Thank you for your time and cooperation.

DEBORAH A. HART, Maj, USAF, NC

2 Atchs
1. Questionnaire
2. Resume'

APPENDIX 2-2

QUESTIONNAIRE INSTRUCTIONS

1. **DO NOT** write your name or social security number on your answer sheet(s). Please sanitize (white-out) any enclosures bearing the name of your medical facility.

2. Please complete the following questions as honestly as possible.

3. Attach additional pages as required.

4. Please try to return your answers to me by 20 December 1986 so I may compile and analyze the data for a project completion date of 1 February 1987.

5. Thank you for your time and cooperation.

APPENDIX 2-3

QUESTIONNAIRE/USAF SCN 86-129

1. Size of Medical Facility: (Please Check One)
   Clinic _____
   Hospital _____
   Regional Hospital _____
   Medical Center _____

2. CONUS _____ OS _____
   (Please Check One)

3. Your current office symbol: SGHN _____ SGN _____
   (Please Check One)

4. Number of Nurses: _____
   (Actual Number)

5. Number of Medical Specialists/Technicians: _____
   (Actual Number)

6. In what Corps is your Hospital Commander? _____

7. In what Corps is your Hospital Administrator? _____

8. What were the results of your most recent HSMI? (Outstanding, Excellent, Satisfactory, Marginal, Unsatisfactory)

   a. SG _____

   b. SGH _____

   c. SGHN/SGN _____

9. What Organizational Chart/System are you currently functioning under? (Please enclose a sanitized copy)

   a. Is it effective? YES _____ NO _____
      (Please Check One)

   b. If you could change it to fit your needs, how would it differ? Why?

10. Do you think the Air Force Nurse Corps would benefit from a standardized organizational structure within our medical facilities?

YES _____ NO _____ Please explain your answer.

11. If you function as SGHN, do you feel your SGH has the time, training, and desire to act in the best interests of the Department of Nursing?

YES _____ NO _____ Please explain your answer.

APPENDIX 2-4

DEBORAH A. HART (Debby)
Major, USAF, NC

Military Resume'

PSC #1 Box 5538
Maxwell AFB, Alabama 36112

SSAN: 323-46-8545
DOR: 1 October 1984
AFSC: 9716/9756

Student/Air Command and Staff College
Maxwell AFB, Alabama 36112
AUTOVON: 875-6794

SERVICE HISTORY

Present	Student ACSC - Residence
May 1984 - April 1986	Hahn AB, Germany
April 1982 - April 1984	Clark AB, R. P.
October 1980 - April 1982	Seymour-Johnson AFB, N. C.
January 1977 - October 1980	Andrews AFB, Washington, D. C.
November 1974 - December 1976	Scott AFB, Illinois

EDUCATION

PME:	SOS - Residence, completed March 1980.
	ACSC - Seminar, completed December 1982.
	NSM - Residence, completed December 1982.
Civilian:	BS in Nursing, 1974, University of Kentucky.
	MSEd in Education and Counseling, 1986, Boston University.

APPENDICES

APPENDICES 3 SERIES

WRITTEN RESPONSES TO QUESTIONS 9, 10, and 11

APPENDIX 3-1

QUESTION 9

What Organizational Chart/System are you currently functioning under?

b. If you could change it to fit your needs, how would it differ? Why?

(Office symbols is parenthesis () indicate respondents current Departmental FAS)

CONUS RESPONDENTS

Respondent 1: SGH is a Lt Col, SGHN is a colonel. I believe that SGHN should work as a staff officer just as SGH, SGO, etc., do. One of the biggest problems in working under SGH is that communication should, in theory, flow upward to SG thru SGH. However, much of the info stops at SGH. Therefore, it means repeating everything twice and/or checking on info to be sure it gets to its source. I don't see any advantage whatever for having SGHN. I think nurses should be recognized as the important staff officers (responsible for 75% of the hospital personnel) that they are, by reflecting them on an organizational chart at the same level as SGD, SGH... (SGHN)

Respondent 2: I work for SG so I wouldn't change. I get along very well with SGH but I prefer to be on same footing with other executive staff members. SGH is also too busy to have anyone else under him. (SGN-waiver)

Respondent 3: I think the Chief Nurse and Nursing Services should always report directly to the SG (not just by waiver, etc.). (SGN)

Respondent 4: Would work directly for SG. (SGHN)

Respondent 5: Change officer symbol to SGN. Puts CN on a true parity with other executive committee members. Numerous taskings/info are distributed to "3-letter office symbols". (SGHN)

Respondent 6: SGN would come under Commander, not SGH. Since

other areas such as Aeromed and Dental come under SG - nursing should also be a direct arm of SG. (SGHN)

Respondent 7: I feel very stongly about this issue. Nurse Executives re: even Chief Nurse of small hospital, should work with SGH not for him/her. SGN should be an equal partner, not the "step child". In the case of this MTF, I'm, treated as a 3-letter chief and expected to perform as such and my rater is the Hospital Commander. I feel I work for the Hospital Commander and coordinate and support the SGH. (SGHN)

Respondent 8: We would return to SGN. Once changed back to SGHN Executive impact definitely decreased. SG now only tells the Chief Nurse when he wants projects completed - does not communicate directly for any other communication. (SGHN)

Respondent 9: The Chief Nurse would work directly for the Hospital Commander; because I think that is the way it should be. That would give the Chief Nurse - Nursing Services - the status and position in the organizational structure I believe they are entitled to. (SGHN)

Respondent 10: Currently in the process (slowly) of being changed to SGN. I'll wait and see what and how they come up with it. Anything will be an improvement. (SGHN)

Respondent 11: Happy with the new organizational change being under SG. (SGN-waiver)

Respondent 12: Nursing should be directly under Commander with an SGN symbol. Reasons: 1. Over 1/3 of the staff (hospital) are nursing personnel. 2. I outrank SGH and all of the physicians. 3. This is the 1st SGH position for the Doctor with less than 10 years service compared to my 19 1/2 years with 4 Chief Nurse positions. 4. One needs the authority commensurate with the responsibilities. (SGHN)

Respondent 13: I developed it to meet my needs. (SGN-waiver)

Respondent 14: SGHN would become SGN and report directly to SG. (SGHN)

Respondent 15: The nursing chain is effective. It is not effective for the Chief Nurse to report to the Chief of Hospital Services and sit on all committees that advise the Commander. For example, if the chain of command is followed SGH will represent SGHN on committees just as SGA represents SGAS, SGAP, SGAF, SGAL, etc. (SGHN)

Respondent 16: The MSC Corps personnel, i.e. Patient Affairs, Logistics, Sqd Commander, etc., are no more important to the functioning/care of the hospital and patients than the physician service chiefs and the charge nurses and should not have 3-letter

office symbols. If this is believed - and I do - than the Chief Nurse should stand equal with the Chief of Dental Services, the Chief of Aerospace Medicine, etc. and represent the Commander of the Hospital at Wing staff meetings and other functions of the Commander depending upon administrative experiences and other tasking. Note: My current circumstances are good. I work for SG primarily because I outrank SGH. SG is an excellent Commander with whom I enjoy excellent communication, give and take. If SGH outranked me, this would probably be dis-allowed (i.e. working under SG) because of the current waiver requirements stated in AFR 168-4. It should be noted that waivers are obtained through MAJCOM from a physician! (SGHN)

Respondent 17: I work for the Commander and feel he is overburdened and has very little time to discuss in-depth problems in Nursing Service. (SGHN)

Respondent 18: SGN - work for Commander. Makes it more difficult when in a smaller facility the CN, as part of the executive team, has same level as 2Lt head of RMO, Patient Affairs. Working for Commander gives more clout. (SGHN)

Respondent 19: Would not change! Our executive team functions extremely well as a team with equal players. SGN has been allowed to assume command for a two week period during absence of SG. SGD has also been allowed to assume command. We also share base requirements such as wing stand-up, battlestaff, etc. (SGN)

Respondent 20: Would not change. (SGHN)

Respondent 21: No change desired. (SGHN)

Respondent 22: Nursing Service should be a separate department. Remove from SGH. (SGHN)

Respondent 23: SGN------>SG. (SGHN)

Respondent 24: Change SGHN to SGN. Largest department. Equal member of executive team. (SGHN)

Respondent 25: Chart does not reflect that presently SGHN's reporting official is SG. Have nursing report directly to Commander to facilitate communications, legitimate Nurse's place on executive team, and establish Department of Nursing as 3-letter office which would validate an up-grade of secretarial position. (SGHN)

Respondent 26: It is functional at this point. Good working relationship with SGH. (SGHN)

Repondent 27: Would change SGHN to SGN, "Director of Nursing Services". Advantages: 1) Would give SGN clearly defined authority commensurate with responsibilities as outlined in AFR

168-4 and JCAH. With present structure, SGHN has responsibility for assuring quality nursing practice and career development for nurse practitioners, outpatient clinic nurses (and 902X0's), nurse anesthetists, and surgical nurses without authority within present structure. (Unlike SGQ that also has manpower resources assigned in other departments). 2) Improve flow of pertinent information to nursing. As SGHN, information is diluted through SGH. Also, non-nursing personnel are not always aware what information or coordination needs to go to nursing. 3) Improve flow of pertinent information upward to SG. 4) Facilitate management and utilization of human and facility resources. One-third of the Commander's resources are nurses and 902X0's. Nursing is also responsible for approximately one-fourth of the facilities floor space. (SGHN)

Respondent 28: No change. (SGN)

Respondent 29: I would have SGHN be SGN. In practically all instances I have the informal responsibility of the other members of the executive staff who work directly for SG. I think that should be formally recognized also. (SGHN)

Respondent 30: Wouldn't change it. (SGN)

Respondent 31: Have already changed it to fit my needs by submitting a waiver for Command Surgeon approval to work directly for SG instead of SGH. I still work with SGH but not for him. (SGN-waiver)

Respondent 32: For what? (SGN)

Respondent 33: Wouldn't change. Waiver to AFR 168-4 allows SGN to work for Commander. (SGN-waiver)

Respondent 34: July 86 changed from SGHN to SGN which is more effective because: 1) Instead of informing SGH, who you expect to tell SG but doesn't, I talk to SG directly and keep SGH informed as required. 2) Largest staff should be 3-letter so even with other departments, i.e. Dental. (SGN-waiver)

Respondent 35: SGN - would report directly to SG. SGH does not have the vaguest idea re: nursing standards. Nursing is viewed as a high manpower pool to be tapped without consideration of 24 hour, 7 day a week obligations, as SGH's are oriented to the 5 day work week. Frequent conflicts between directions of SG and SGH, in priorities. SGN should be on equal level of SGM, SGL, SGP, SGF. (SGHN)

OVERSEAS RESPONDENTS

Respondent 36: No changes. (SGN)

Respondent 37: Change to SGN. SGH is part-time with a heavy psychiatric patient clinic. Most of the time, I deal with Commander directly anyway. The Commander had mentioned changing me to SGN before she was assigned here. Now the Command SG wants us to all stay SGHN regardless of size of service or part-time SGH, so she won't pursue this but told me to report directly to her. SGH remains my rater. (SGHN)

Respondent 38: Responsible to Commander rather than SGH. (SGHN)

Respondent 39: Have Nursing Services report directly to the Commander. SGH currently has 18 direct reporting departments/services; far too many for effective and timely management. Span of control is unwieldly. In-basket paperwork is often delay in routing secondary to tremendous load. (SGHN)

Respondent 40: Make SGHN lateral to SGH - reporting directly to SG. (SGHN)

Respondent 41: Yes, I strongly believe that Nursing Services should report directly to the Commander. The Chief Nurse has much the same responsibility and authority as the other executive comittee members. Our Command Surgeon also feels that "rank inversion" is not a consideration, this too is very inappropriate. (SGHN)

Respondent 42: One person in charge. The other five working as a team - each running/managing their own areas but planning the hospital activities as a group. SG-->SGP, SGA, SGN, SGD, SGH. (SGHN)

Respondent 43: Would not change - I like working for the Commander directly. (SGN)

Respondent 44: No change required. (SGN)

Respondent 45: No change. (SGN)

Respondent 46: SG should be the CN's reporting official. In most small facilities the SGH is a part-time, junior MD with no previous experience in administration. It's difficult to get direction from an individual who is less experienced than you in these matters. (SGHN)

Respondent 47: I would have the Chief Nurse reporting directly to the Commander. I personally feel that the nurse is the expert in nursing, just as the administrator is expert in administrative affairs, and Chief, Hospital Services expert in medicine. Nursing should be on same level as the other Corps chiefs. (SGHN)

Respondent 48: Have the Chief Nurse report directly to the MTF Commander. Numerous reasons: 1) Many of the Commander programs

are assigned to Nursing Services, easier for coordination. 2) Nursing Services, for working relations, should have direct access to the Commander. 3) Nursing Servies is considered a separate unit when it comes to regulations, inspections, etc., yet not when it comes to authority. 4) I think it might help cut down on the "dumping" syndrome so often felt by nursing personnel. Must add that in my situation I outrank the SGH so my reporting official is the Clinic Commander. Additionally, I've been fortunate to have two excellent, interested, though inexperienced SGH's. (SGHN)

Respondent 49: SGN - I must work as SGN anyway - SGH gives little or no support because he does not have time nor inclinition. (SGHN)

Respondent 50: Put Chief, Nursing Services under Commander. (SGHN)

Respondent 51: The plan that is enclosed was the organizational system until a few months ago. At that time, the USAFE/SG made a rule that all SGN's would come under SGH. We have gone in with a waiver but I have little hope for success. (SGHN)

Respondent 52: SGHN should be SGN in all facilities. (SGHN)

Responent 53: The Chief Nurse should report directly to SG. If Dental and the Administrator report directly to SG, why not Nursing? I've heard it stated that nursing reports to SGH as part of his "training" to become a future SG. There are many SG's that were never SGH. (SGHN)

Respondent 54: In my particular situation, because of the personalities involved, I find it easier and more effective to be working for SGH. However, I feel because of manning, number of people supervised by nursing service, the Chief Nurse should work for SG. One change I would make, regardless of circumstances, would be to pull SGA out of the top box with SG. Expecially at smaller facilities with younger, less-experienced SGA's, this is not a suitable or effective form of management. SGA, as the responsible person for administrative functions within the MTF should be at the same level as SGN (responsible for nursing care) and SGH (responsible for clinical management). (SGHN)

Respondent 55: No changes needed, from the nursing standpoint. However, a more effective system might group the non-provider "services" (i.e. x-ray, lab, pharmacy, etc.) under a senior BSC who more clearly understand their needs and requirments. Thus, the SGH would become a Chief of Professional Services with a parallel 3-letter position of Chief of Support Services (perhaps SGK). (SGN)

Respondent 56: Instead, would be SGN. SGH is a nice man, but is looking for a fellowship and not in the habit of rocking the

boat. Usually he downplays problems/situations which SG should be aware of. I go to SG anyway, but this does, on occassion, cause friction. (SGHN)

Respondent 57: Be SGN and on same level as other 3-letter symbols. Reasons: 1) Be able to get nursing concerns direct to SG and other executive members. 2) Nursing does not function as well under SGH due to broad spectrum historical view of medical staff toward nursing. Changing attitudes much too slow to make growing nursing needs and requirements. (SGHN)

Respondent 58: Chart currently under revision. Present one has not included nursing. Be included on chart. Even though I'm SGHN, in actual fact I'm SGN. I report directly to SG. (SGHN)

Respondent 59: The Chief Nurse should work directly for the DBMS. Just as the Chief of Clinical/Hospital Services is considered the expert in medical practices, so is the Chief Nurse the expert in nursing practices. (SGN)

Respondent 60: Place the Chief Nurse under SG as equal with SGH, SGD, SGA, and SGP. (SGHN)

Respondent 61: You will probably notice that Nursing Service is not on this chart. When I arrived I asked where it was! I was told it came under SGH and was integrated. The new format is being drawn up and shows Nursing Services on the chart of the organization. Nursing really does exist and the exec. staff recognized this - it was an oversight and may I add Nursing continues to educate throughout the world, not just here. Nursing is treated well and respected at this facility - so I just smile and say if this is the only problem I have I'm lucky!

APPENDIX 3-2

QUESTION 10

Do you think the Air Force Nurse Corps would benefit from a standardized organizational structure within our medical facilities? Please explain your answer.

CONUS RESPONDENTS

Respondent 1: I feel quite strongly that Chief Nurse should work directly for Commander and that this should be standardized, rather than submitting waiver request each assignment. Plus, waivers are generally approved for two years only.

Respondent 2: Though at our clinic, Nursing Service aligned under SGH works fine, I believe that alignment under SG is more reasonable. SGH directs medical activities, and SGN directs nursing activities, and should function as peers in the management structure. At our facility, the SGH and I basically function as the medical and nursing management experts - we coordinate as management peers (rather than superordinate and subordinate) and brief the SG on our activities.

Respondent 3: I feel all Chief Nurses or Chairperson, Department of Nursing should work directly for the Commander.

Respondent 4: It depends upon the players! Some need the organizational structure so they know where they stand - in other situations, it depends upon the dynamics of the "3-letter" Chiefs to work toward the common goal. I work "for" no one, simply with!

Respondent 5: Based on my experiences in having worked for either the SGH or SG, I would prefer to work directly for the SG. In smaller facilities, the organization probably runs better when the Chief Nurse works directly for the SG. In the Medical Center, the management of performance reports could be a problem

since nearly 1/3 of the personnel are in the Department of Nursing (at my facility).

Respondent 6: Yes, then it would decrease individual problems in moving from base to base. Nursing departments would not be at the will of the Commander and/or SGH.

Respondent 7: No, I think most follow the same guidelines.
Respondent 8: I feel all Chief Nurses should work directly for the Commander and be on equal level with SGH executive management.

Respondent 9: The DBMS and the Chief Nurse must have a strong line of communication and this is best accomplished by the SGN working directly for the DBMS. This, in no way, lessens the Chief Nurse's responsibility to keep the SGH informed.

Respondent 10: As to who the Chief Nurse works for depends on too many variables within each institution. Rank, rank inversion, problems within SGH or SG, interdepartmental friction all play a part in determining the success of the Chief Nurse. Each insitution needs flexibility.

Respondent 11: No, all hospitals differ. The Chief Nurse should be equal to SGH and report directly to the Commander.

Respondent 12: I believe all Chief Nurses should work directly for the Hospital Commander without requiring a waiver. I believe it reinforces his/her position as a member of the executive team and equalizes the power structure with both the MC and MSC's.

Respondent 13: Since we move so often from station to station, transitions would be easier. Communications, facility to facility would be enhanced.

Respondent 14: I think all Chief Nurses should be assigned as SGN and be the Chief of the Department of Nursing Services just as the other executive team members, i.e. SGD, SGA, SGH, are assigned under the Commander. This would make him/her equal to the other executive members. The Chief Nurse frequently has more management experience and skill than the SGH. I think AFR 168-4 should be revised to give nursing equal status since nursing personnel comprise more staff than most any other section in the hospital.

Respondent 15: It is standardized in the regulation. Each hospital has some individual needs (i.e. specialty areas that may or may not exist in other hospitals). Each one therefore needs it's own.

Respondent 16: SGN should come under SG and not SGH since it is a major department providing a vital function and mission in peacetime and wartime.

Respondent 17: I feel the flexibility must stay with the Commander and executive branch to allow for changes depending on personalities, management styles, philosophies, and organizational goals.

Respondent 18: According to AFR 168-4, there are standardized charts for all departments. When you are standardized, we can have one focal voice as an advocate if a situation needs change. It's hard to please or not affect everyone when, everyone has a different orgainzational structure. It seems to me, we would be stronger as a Corps in unity than united in difference.

Respondent 19: Structure needed depends on the mission, the services available, and at times expertise assigned.

Respondent 20: Within a certain degree. There should be some standardization at the executive level and guidelines for setting-up nursing service organizational structure, with enough openness to meet the individual hospital size and type of personnel.

Respondent 21: Extremely time consuming to write for exception to oganizational structure as listed in AFR 168-4. The main reason that SGHN remains SGHN instead of SGN is that SGH must have X-factor of personnel supervised in order to have the number of support staff required for his position. Only by having nursing personnel does he/she gain the number. Manpower requirements should be modified to meet scope rather than numbers.

Respondent 22: If done by bed size. For other reasons already given, SGHN should come under SG.

Respondent 23: Feel all Chief Nurses should work for the Commander. SGN has the most resources - people, money, and most direct link to patients.

Respondent 24: No. I don't think it would matter much except to look good on paper unless the Dept of Nursing and Clinical Services both fell on the same level of authority under the Commander.

Respondent 25: Instead of each nurse requesting a waiver to work for SG which could easily get disapproved by the local medical facility commander, allow the Chief Nurse, across the board, to work directly for SG. Chances for higher OER endorsements are available without the Chief Nurse begging for the endorsement. Some Commanders ahve expressed they know of no nurse deserving of higher endoresments and this is a fact.

Respondent 26: Much is dependent on personalities/abilities of individuals above you as well as their style of

leadership/management. Have worked for SGH and SG. Both responsive - but different style - let me do my thing without interfering. As SGHN always had access to Commander. I analyzed their style shortly after I got job and tailored my actions etc. to their style. Fortunately, while we may differ in some things, our basic philosophy has been the same.

Respondent 27: Standardized with all Chief Nurses as SGN rather than SGHN. Reasons: 1) Direct communication with SG. 2) Especially important in the many small facilities - Chief Nurse frequently outranks SGH, SGH a part-time job, and SGH unable to understand nurses' responsibilities. 3) Large percentage of personnel work for SGHN.

Respondent 28: Feel that Chief Nurse should always function as three-letter department directly under the Commander due to level of SGN involvement in organizational and base activities and the need to coordinate in a timely manner. SGH is frequently tied up in direct patient care activities and pulling MOD and is not accessible when needed. I feel that SG is often more inclined to encourage and allow creativity and experimentation than SGH. Also feel strongly that Chief Nurses today are academically and experientially equipped to manage all nursing activities on a par with all other professions and should be recognized as executives and given the appropriate responsibilities and authority commensurate with the position. As professionals, nurses must work with, as opposed to for, the medical staff and this is more satisfactorily arrived at under the Commander.

Respondent 29: Would certainly reduce confusion. In addition, in smaller facilities, the Chief Nurse frequently is of a higher grade and more experienced than SGH. In practice, therefore, the Chief Nurse functions as SGN.

Respondent 30: Currently nursing does have a standardized organizational structure (see AFR 168-4) for which we must obtain a waiver if we want to be SGN.

Respondent 31: We are professionals. We are expected to contribute as equals but are not organizationally. All Chief Nurses should report to SG.

Respondent 32: Get them out from under SGH. Nursing is too large a service/department in most AF hospitals not to have equal voice in hospital governance. If you get an ineffective SGH, the only way to operate effectively is to replace or go around him. Neither option is feasible in most cases. Nurses have (usually) much more experience and education in administrative/management than most physicians. Additionally, nurses have been and still are the "conscience" of medicine and run their service "conscientiously" more often than not.

Respondent 33: But, not all hospitals are the same so to standardize organizational structure of facilities would be somewhat impractical.

Respondent 34: Needs vary from facility to facility.

Respondent 35: All SGN's and SGHN's should come under SG not SGH. They should be lateral to other members of the executive team.

Respondent 36: Most decidedly so! Nursing must be given greater authority and accountability for its own actions as SGN. Nurses have greater experience in management and dealing with people from charge nurse position on up and certainly can manage their own departments. SGH has a full time job on their hands without worrying over nursing concerns (which they usually don't understand and refer to the CN anyway!). SGH and SGN who are usually peers can work together, if given equal status on the executive committee. Have made this recommendation to our MAJCOM for changes to AFR 168-4.

Respondent 37: Feel we should work for SG.

Respondent 38: Unsure. Rank structure frequently precludes functioning under a standard organizational chart.

Respondent 39: If it means coming under SG, YES! I was personally embarrassed - hopefully the SG was too, to find that I was left off the key personnel listing presented to the HSMI because of the current organizational chart in AFR.

Respondent 40: The organizational structure is already defined in AFR 168-4.

Respondent 41: Continuity - and Chief Nurse would not have to redefine her position with each new assignment.

Respondent 42: Majority of nurses are more experienced than SGH and in small facilities SGA is inexperienced. Feel nurses should work for SG.

Respondent 43: Most are standardized in conjunction with AFR 168-4. I feel nursing should and deserves proper recognition as a three symbol office and be placed on the same level as the Dental Corps and MSC Corps.

Respondent 44: Depends on circumstances of each facility.

Respondent 45: Nursing is definitely the backbone of the clinic/hospital, has more personnel than other sections, and all should be SGN's.

Respondent 46: It would alleviate addressing mistakes as we'd all be SGN's. Many nurses may outrank their SGH's also.

Respondent 47: Chief Nurses should work for the SG. She/he is responsible for the largest portion of the hospital resources - personnel, budget, equipment, and patient care areas. Today the SGH has too many responsibilities, especially QA; nursing is one area he doesn't need to supervise directly. Chief Nurses should have direct access to the Commander. Working for the SG at one facility and SGH at the next creates role confusion. Ncw that nurses are being selected for Hospital Commander positions, they need direct exposure to that function.

Respondent 48: It irritates me that there are still MTF's with SGHN. I think this is "behind the times" and recognition of the dedication and work that most SGN's and nurses perform, i.e. hold the MTF together, is long overdue!

Respondent 49: Standardizing organizational structure would help prevent management ping-pong as the individuals who fill positions change.

Respondent 50: IF that structure is as I suggested earlier, i.e SGN rather than SGHN - for the reason already stated - plus access to higher level raters/endorsers for nursing service personnel. Some nurses enjoy that status presantly - for various reasons - and I believe that all Chief Nurses/Nursing Services were in that position, nursing services would fare better and get a "fairer shake" across the board. Chief Nurses should be better able to deal with Hospital Administrators, etc. who sometimes take advantage of their "3-digit office symbol" status.

Respondent 51: Just put all SGN directly under SG. For equal, participation, vote, recognition, and salvation of NC careers. Look forward to the days when the SG is a AFNC officer.

Respondent 52: The American Hospital Association recently spoke to the role of nursing services' as one of the larger, more essential departments within a MTF. As such, the Chief Nurse must have the executive, management status encompassed in a direct line - not indirect through the SGH to the SG.

Respondent 53: Yes, to eliminate confusion from hospital to hospital.

OVERSEAS RESPONDENTS

Respondent 54: I think for consistency in OER's and work expectations, there should be standard structure. Suggest SGN under Commander because we are such a major section of the facility. Also think OR nurses should be under SGN for career development and better control of OER's.

Respondent 55: In medical centers or larger facilities, SGHN should be SGN as an equal entity - especially if the Chief Nurse outranks SGH. Too many times SGN carries SGH when it is SGHN. SGN can guide and assist, usually better, if their hands are not tied by SGH. Face it - SGN usually can manage, organize, and lead circles around SGH. As for regs and "AF know how", we have the knowledge and experience. Give us credit for our expertise. Don't hamper progress by keeping SGN under SGH.

Respondent 56: This would eliminate changes by Command Surgeon or DBMS to fit their whims when it is not always beneficial for the Chief Nurse to work under SGH.

Respondent 57: It needs to be considered from the organizational level, not Air Force.

Respondent 58: The organizational structure must remain flexible.

Respondent 59: It would ensure equal voice and authority for the Chief Nurse throughout all AF MTF's.

Respondent 60: Absolutely - then personality and local preference does not play a part. TAC has agreed that all Chief Nurses directly report to SG.

Respondent 61: <u>If</u> the standardized structure makes SGN under SG.

Respondent 62: Place under SG, commensurate with other department chairpersons. We are well-educated, personnel managers who deserve an equal footing. A certain AF General (MC) states, "Young SGH's need to supervise the Chief Nurse to learn more about management." I strongly disagree. Young SGH's are not usually as willing to learn from a subordinate as they are from a peer. Also, <u>nurses</u> learn management through supervision of <u>nurses</u>. Why can't physicians hone their own management skills by supervising young physicians AND NOT SEASONED NURSE MANAGERS!

Respondent 63: By standardizing organizational charts (and presumably assigning appropriate AFSC's against positions in the chart) we would have a means to better assure that the most qualified officer is administering services/departments and representing the needs, goals, and objectives of that service/department at executive level.

Respondent 64: No. Depends on rank, experience, interest SGH/SG. It should be an individual matter and discussed with command nurse, hospital commander, etc. Whatever is best to promote the career of the individuals concerned should be used.

Respondent 65: If the Chief Nurse worked for the SGH - NO!

Respondent 66: It would alleviate the problem of where to put nursing. Nursing is the only group that appears to fall under the whim of Commanders. They mouth the words, "you are part of the executive staff and equal," but we as nurses are the only member of the executive staff who works for another member. I feel it's a hold over from the nurse's hand maiden role.

Respondent 67: No, Because the needs of large, medium, and small facilities are different. The only change would be to put the Chief, Nursing Services under the Commander.

Respondent 68: A standardized organizational structure does exist - AFR 168-4. However, to have a department with 400 people on the same par level as a department with 4 people - SGHG, (primary care), makes little management sense. The Chief Nurse is a member of ALL executive committees, yet the only 4-letter symbol present. Linen control (SGL) works for the Commander.

Respondent 69: I've been in the USAF NC for 18 years and I do not believe I've seen any two organizational charts alike. I definitely feel we as a Corps would benefit from continuity and authority on the same level/plain as all other Department Chiefs.

Respondent 70: Definitely - The Chief Nurse should be under SG, especially in free standing clinics and small to medium size hospitals where SGH is an additional duty.

Respondent 71: No. 1) We currently have both SGN's and SGHN's. 2) Sizes of staffing varies at each facility and organizational structure is determined by the Commander. 3) It would eliminate any flexibility for the Chief Nurse to place individuals where they could be best utilized. 4) Currently - a large number of nurses fill slots outside nursing service (QA/RM, HPC) which gives the CN only an indirect line of supervision and/or control.

Respondent 72: Yes and No. Standardized, convenient, always clear and understood. But situations, rank structure, etc. vary making it very hard to have one standard adequate for all facilities.

Respondent 73: Yes, if the organization would place nursing directly under the Commander. I have worked both as SGHN and SGN and find nursing needs to have a direct voice to the Commander.

Respondent 74: I think the Hospital organizational chart should be standardized. The nursing already is. I think nursing should have the autonomy, responsibility, and accountability for managing their own areas and evaluating their own standards of care.

Respondent 75: Organizational structure should fit the organization, personalities, and circumstances.

Respondent 76: I believe that different size MTF's do have different organizational needs at different times. The rank of any given individual often makes it necessary for "waivers" to the current standardized structure on AFR 168-4.

Respondent 77: Believe all Departments of Nursing should work for the Commander. This would increase nursings power base and nursing autonomy. Nursing is the largest department in any size facility, be it a clinic or medical center, and therefore should be recognized as a major contributor to the health care system. Working for the commander would also be in line with civilian facilities, i.e. civilian nursing works for the Chief Executive Officer (CEO) and not the Chief of Staff (physician position). Power is equal for both nursing and physician staff. Accountability of nursing is also increased when working directly for the CEO.

Respondent 78: I believe the Chief Nurse should always work for the facility Commander. Most SGH's are inexperienced, and work part-time as SGH. Their span of control is too large when it includes nursing services. Chief Nurses are colleagues and equal members of executive teams in many facilities. To reflect this, it should be SGN across the board. My situation is interesting as I outrank our Lt Col Commander as well as the other executive team members. It is not appropriate for me to work for the SGH because of that and because of the number of people he supervises.

Respondent 79: I think all facilities should use the SGN model. With the demands and complexities of both medicine and nursing, I don't think it is practical or beneficial to have nursing work for the SGH. It certainly makes it easier if the SGH is competent and supportive of nursing. Where this is not the case, it makes for great difficulties in getting the job done.

Respondent 80: The structure should be standardized according facility size. I believe structure should make Nursing SGN. However, nothing is perfect and an option (s) to the structure should be available just in case. My answer is more positive than negative. Standardization allows everyone to know their parameters, no guessing, no being careful because you may step on toes, and it allows a more positive interaction to evolve between all concerned in a shorter time.

Respondent 81: Standardize the organizational structure (AF) to make the Chief Nurse a three-letter chief. As a member of the executive staff, the Chief Nurse functions as such but many times without the authority to do so.

Repondent 82: We must be formally recognized as a Dept., standing independently - close SGH coordination is always needed but rarely does Chief Nurse have authority to fulfill the responsibilities as does SGA, SGD, SGP.

Respondent 83: There are a variety of Medical Facilities in the AF. Many of these have specialized functions and missions. I don't believe a standardized organizational format would meet their specialized needs.

Respondent 84: All hospitals differ. The Chief Nurse should be equal to SGH and report directly to the Commander.

Respondent 85: A standardized organizational structure would seem more appropriate for larger medical facilities where usually the SG, SGH, SGA, and SGN are quite senior. Smaller organizations need to have flexibility in their structure.

Respondent 86: In Medical Centers or large facilities, SGHN should be SGN as an equal entity, esp. if the Chief Nurse outranks SGH. Too many times SGN carries SGH when it is SGHN. SGN can guide and assist usually better if their hands are not tied by SGH. Face it - SGN usually can manage, organize, and lead circles around SGH. As for regs and "AF know how", we have the knowledge and experience. Give us credit for our expertise. Don't hamper progress by keeping SGN under SGH.

Respondent 87: This would eliminate changes by Command Surgeon of DBMS to fit their whims when it is not always beneficial for the Chief Nurse to work under SGH.

APPENDIX 3-3

QUESTION 11

If you function as SGHN, do you feel your SGH has the time, training, and desire to act in the best interests of the Department of Nursing? Please explain your answer.

CONUS RESPONDENTS

Respondent 1: In this particular situation, SGH is more qualified than SG - he is a micromanager, whereas SGH highly respects and works with Nursing Service. In most instances, I feel it is better all around to work under SG, example: easier to get Wing endorsements as the next person in the chain. Nursing Services should not come under Administrator. I can work with either SG or SGH but do not like the idea of some nursing staffs coming SGA.

Respondent 2: Won waiver approval here, plus gained secretary to manage. SGHN over my 4 years as Chief Nurse. SGH ineffective for any type administrative support and often lacked experience.

Respondent 3: I consider myself fortunate in that my SGH has taken the time to find out what Nursing can offer. I believe it is an essential responsibility of the Chief Nurse to educate, by example and info, other executive staff members concerning the function and role of Nursing. My SGH asks my opinion and respects my knowledge. I can do what is right for Nursing Services. However, generally speaking, SGH may have the desire to act in the "best" interest of Nursing but certainly does not have the time or specific training (knowledge) necessary to determine what is "best" for the Department of Nursing. Nursing should determine what is "best" for the Department of Nursing and work in harmony with other Executive Staff and medical personnel to achieve requirements of the mission.

Respondent 4: My SGH has the desire to act in the best interest of Nursing and does, however considering the scope of his other responsibilities, he does not have time to become involved in the full range of activities, programs, responsibilities, etc within Nursing Services. SGH is a physician and physicians aren't nurses nor do they fully comprehend what we do.

Respondent 5: In our institution - SGHN is a division as is SGHS, SGHM, SGHP, and SGHQ. We five division chiefs work well and together with SGH as executive board of Med. Staff. Most appropriate when 89% of the Medical Center responsibilities and resources are SGH related.

Respondent 6: I work as SGN. But in fact, SGH does not have the training or desire to act in the best interests of Nursing Service. Chief Nurses greatly support SGH's by advising and informing them of management, disciplinary, and organizational issues.

Respondent 7: The SGH is supportive. However, he lacks the time and the managerial skills to act as supervisor to the Chief Nurse. An inexperienced nurse administrator would not be able to obtain the advice and guidance she would need. Fortunately, this has not occurred here.

Respondent 8: I think SGH does, but only nurses are interested in the Department. So there's a choice between Dr's and nurses. SGH will choose in favor of the MD.

Respondent 9: I function under the Commander as SGN, my SGH is very supportive and easy to work <u>WITH</u>.

Respondent 10: My SGH is brand new in his job and is still learning the ropes. Part of my job is to help him learn to be an effective SGH and to do staff work for him. We function in a "participative management" environment in our organization. However, when I first came into my position, the SGH gave me the impression he didn't have time for Nursing Service. He was so busy putting out fires in the rest of the place, I could hardly get a 15 minute appointment. If I had not been secure in my role (and had the perception of good support from the SG) it could have led to alienation of the Department of Nursing. I have learned that no matter who the Chief Nurse works for (SGH/SG) the most important factor is team work with the SGH in getting the job done. The Chief Nurse and SGH should "fit" well together like a pair of gloves. When that happens, the whole organization "hums". Another aspect is power. If I have legitimatized my power through my actions and knowledge, I can get the job done no matter who I work for.

Respondent 11: Most of SGH's time is required to train the new physicians on the art and acience of military medicine. Once again, the dynamics should not reflect one department or the other, but a concerted team effort to achieve quality care in the most compassionate/non-judgmental manner possible. Sounds like team work.

Respondent 12: I did function as SGHN and <u>NO</u> I do not feel the SGH had the time or really cared what Nursing was doing.

Respondent 13: The SGH is highly knowledgable of the daily working of all the clinics - we communicate daily. He has more time to spend coordinating needs, problems, etc, with Nursing Services than does the SG, who is often gone 2-4 hours a day to Wing activities, and frankly does not want to be bothered with many of the day-to-day decisions and problems. However, if we were SGN rather than SGHN, I would still communicate with SGH as noted, since we actually function as peers. NOTE: though Nursing Services is aligned under SGH, my reporting official is SG, since I outrank SGH. I imagine this occurs in other facilities, too.

Respondent 14: I was SGHN until one month ago. Most SGH positions are filled by first time SGH's. Most do not know chain of command, organizational structure and or other Corps requirements. Often most hate their job and make life unbearable for those of us which have come up through the ranks. Let's face it, "this is still a man's world" not much has been done to protect the NC. Being SGN helps in executive decision making, one is included in more Wing activities; prior to this only SGA, SGP, and SGD were included.

Respondent 15: No, however, by the time Chief Nurse is a Colonel she/he really carries the department. I feel Department of Nursing should fall under SG. In many instances, the SGH has minimal military and management experience compared to the Chief Nurse. This is particularly true at small hospitals and poses a problem.

Respondent 16: Don't think he cares to learn, most of the time.

Respondent 17: Many SGH's are non-volunteers who have no or very little interest in administration. The two week course they attend is inadequate preparation for the job. Most are Drs with very little knowledge of the Air Force excluding the Medical Corps. They are poor managers of time, resources, and personnel and if you don't have a strong SG and SGA you are sunk.

Respondent 18: I function as SGN - the SGH is very supportive at the facility at this time.

Respondent 19: SGH actively seeks input from Chief Nurse and is very supportive.

Respondent 20: Time and desire - Yes. Training - No.

Respondent 21: In my past three assignments, I have had ample opportunity to observe SGH at close hand. Even when you have a good guy in SGH the potential is there for "skipping over" the Chief Nurse and going about their business though SGHN does not exist. You are left off of ad hoc committees - the outcomes of which directly affect Nursing Services and or personnel. You are frequently omitted from impromptu, informal meetings on limited

subject matter. You may be left out of standing meetings of "executive staff" members excluding the Chief Nurse, "because SGH represents services and you are a 4-letter office symbol. There may be no minutes to these meetings - absolutely no record of what was said and if you get any info, it's not always accurate and may actually be tailored to meet their needs - not yours or Nursing Services. In most instances, SGH has little admin experience or knowledge - some have not read JCAH standards, IG checklists, AFR 168-4, ARF 160-12. I have sat on Credential's Committees where SGH is unaware of the regulations guiding the review/voting --- he's the Chairman! SGH frequently is an MD, 1-2 years out of a residency program. In some instances, is not board certified on any speciality and may have the job simply because he is the best qualified of a staff with no admin experience. In my particular position at present, SGH has it by default. He is separating Summer '87 and he is more interested in his clinical practice/finding a civilian job, than in efforts towards improving his admin capabilities. He frequently presents policy to the rest of the provider staff as another AF idiosyncrasy, rather than a JCAH STD, CDC recommendation, or a policy established which in fact represents good logical thinking followed by an equally logical conclusion which makes good sense. Why do we have an SGH like this? Because, there is no one else apparently available. Another reason why SGH as a reporting official does not work, he is still a physician first and is often a peer of the other providers. ADD: Communication with SG is vital to SGHN and the rest of the executive staff. Location of the Chief Nurses' office has much effect on whether or not you are included in daily happenings. SGH really doesn't have time to devote to Nursing Service and frequently little inclination.

Respondent 22: Time is limited. Training is nil. Desires good working relations but does not have backing or desire to side with nurses against physicians on any issue.

Respondent 23: N/A since we are SGN. However, SGH would have neither the time nor experience to act in the best interests of Nursing. He is, as are many physicians, unclear about the role of Nursing. In fact, he frequently seeks SGN's advice about concerns with X-ray, pharmacy, etc.

Respondent 24: SGH new in AF (1 Yr), does not know much about AF management. I am training SGH.

Respondent 25: The current SGH at this facility is the best. He is a strong doctor, clinically expert, and extremely motivated in administratve procedures. He is an exceptional administrator. He is one in a million. He supports nursing 100% and we work together on all matters that relate to the medical service. Outstanding SGH. He is willing to let SGHN be SGN.

Repondent 26: I did above. But additionally, he is very protective of physicians - even when they are dead wrong. You

can't operated equitably and objectively when you "protect" one of the groups under you more than others. Good SGH's are hard to find because all of them are MD's! The MD "mentality" (if you will) does not lend itself to management expertise.

Respondent 27: Time - no. Training - no. Desire - prehaps. SGH has a big enough job to do without me. I report to SG because I outrank SGH. It would be counterproductive to have to go through SGH.

Respondent 28: Some do and some don't. Ours does fairly well most of the time. Regardless of where Nursing falls on the organizational chart, we still must interface with SGH when addressing problems with the professional staff.

Respondent 29: Present SGH has the desire and tries to "be fair", but does not have the time nor the training (standards of practice for nursing, management knowledge).

Respondent 30: In my situation at a Med Center, I have an experienced physician as SGH and he makes every effort to understand the job of the nurses as well as support of the Dept of Nursing. Often the working relationship between SGH and SGHN is dependent on the personal bias of the SGH. The SGH will never completely understand nursing in my view.

Respondent 31: SGH is required to see patients which could take 1/2 to 3/4's of his day. SGH, as well as SG, do not understand the scope of Nurisng. The Chief Nurse is a member of the executive team and as such, deserves credit to work directly with SG as all others. The all others could easily wear less rank than the Chief Nurse. No, SGH nor SG, in some instances, do not have the desire to act in the best interests of the Department of Nursing.

Respondent 32: I'll answer from <u>past</u> experience under <u>SGH</u>. They generally do not have training, understanding, or experience with Nursing needs or goals.

Respondent 33: Although my office symbol is SGHN, my supervisor is the SG. This chain of command works much better than the one at my previous assignment when I was supervised by the SGH. He was too busy to supervise Nursing Services and did not act in the best interests of Nursing Services. We were both majors and when I was selected for Lt Col before he was, he resented my promotion. I got along much better with the Commander then I did with the Chief of Clinic Services. Since I had only been assigned at this hospital for five weeks, it is difficult to assess the "political" atmosphere.

Respondent 34: Office symbol is SGHN but waiver permits me to be rated directly by SG.

Respondent 35: I am fortunate. My present SGH is a pleasure to work with - more of a colleague than boss. Actually, if I were new, inexperienced CN, he might not have the training/experience to act in our best interest - but his heart would be in the right place! (I think). My SG is also very supportive and agrees that it should be SGN, but command says "NO". Not always my experience, though. Think standardized SG-SGN structure would solve a lot of problems for us. We deserve that!

Respondent 36: They try but, usually the lack of understanding is phenomenal.

Respondent 37: My current SGH is a cut above the usual. Although young, only one year on AD, he is knowledgable and willing to work the issues. He is far superior to previous SGH (04) that was in place upon my arrival one year ago. NOTE: This study is long overdue, also, now will something be done about this appalling situation, re: 2nd class citizenship for SGHN!

Respondent 38: He means well, wonderful to work with. However, he does not have the time and certainly not the experience. Most SGH's rely heavily on the Chief Nurse for guidance and assistance.

Respondent 39: He is too busy doing 2A, surgery, and keeping track of Doctors. I feel I get the most help and committment from the Commander directly.

Respondent 40: Time - yes. Training - no. This is his first SGH position. I've been in upper level management for about seven years. I've been teaching-working with him to assure that projects get coordinated, communication is appropriate, etc. Desire - yes. The bottom line is it's the people that make it work. Regardless of whether there's an "H" in the Nursing Symbol. It's a matter of principle that all other Corps Chief work for the Commander and SGHN is dropped DOWN one!!

Respondent 41: Comment: Many SGH's lack the experience, both AF and managerial experience, necessary to "administrate" clinic services activities, much less to coordinate Nursing Service functions. An inexperienced SGH (to whom an SGHN may report) can be a real hindrance to effectively manage a Nursing Services.

Respondent 42: I have a new SGH - he cares about patient, MC, NC members. My old SGH, could care less about the Department of Nursing for three reasons: 1) He didn't want SGH, 2) He didn't know or care about his SGH job, and 3) He only cared about his own AFSC.

Respondent 43: The SGH is normally a physician who is seeing patients and is concerned with the medical aspect of patients. They have very little background in administration and personnel mamagement. Nursing Service has a specific goal and objective

and should be given the authority to deal with problems directly not go through SGH. Most SGH's have no idea what Nursing Service consists of and what the role entails.

Respondent 44: Even at a clinical level, the SGH seems only preoccupied with the providers and not the integration of Nursing with them for the sake of educational activities.

Respondent 45: I did function as SGHN and did not feel he had time, training, or management skill to act in the best interest of Nursing. SGH's feel Nursing can do everythin because they have more staff. No one understands the importance of nursing education or what they do.

Respondent 46: Most SGH's have not spent the time/energy to study/know the standards as established by JCAH/specialities etc. Their orientation is toward their clinical specialty rather than the specialty of administration and most Chief Nurses spend an enormous amount of time interpreting AF policies/standards to their boss.

OVERSEAS RESPONDENTS

Respondent 47: N/A at my present assignment, but have been in this situation in the past. I feel very stongly that Nursing should always be directly under SG. I do work for and with SG on a daily basis and have for years. It should not require a waiver to do so. I own a large share of the hospital's area, am an executive team member with as many responsibilities as SGH. To place me under a part-time SGH is an insult and does not reflect my function.

Respondent 48: Although I am SGN, my preception of our SGH is: 1) His primary goal is to control Nursing Service. 2) He is not interested in the job - he would rather see patients. 3) He has indicated very little concern about the needs or interests of NS. 4) He certainly has no knowledge of NS's organizational structure although I have pointed it out to him on many occassions. He continues to "direct" and "guide" nurses and techs and assign additional duties without coordinating with me. He is trainable but it is a very time consuming job which requires more of my time than I feel I should have to give to it.

Respondent 49: Not a chance!

Respondent 50: It has been my experience that the SGH's have neither the time, interest, or know-how to be of any assistance to Nursing Services. In the clinic setting there is far more concern over who has authority over what section rather than patient care, purpose, and/or technician training.

Respondent 51: My present boss does very well. However, most of

the SGH's I have seen do not have enough time, training, or desire. That is why I feel the Chief, Nursing Services should be directly under the MTF Commander.

Respondent 52: Most SGH's in small facilities (of which we have many) are first time SGH's. They have neither the training nor in most cases the desire for administration.

Respondent 53: Most of the MD's don't have the time, training, let alone desire to utilize Nursing to its fullest potential and still comply with legal constraints.

Respondent 54: Yes, my SGH has the desire and the time and we work well together and for the interests of nursing. However, I feel SG has the same interests in mind.

Respondent 55: Although I function as an SGN, I elect to respond to this question. While my SGH is extremely knowledgable of physician standards and practice, he is totally unaware of the needs/requirements and standards of practice for nurses, 902X0's, and nurse practitioners and PA's. Only by consistently challenging his [MD] positions on their practice and insisting on adherence to practice acts and credentialing guidelines, the Chief Nurse in the facility is able to assure that non-physician care givers are providing care within their scopes of practice. Physicians are simply not prepared to manage the wide scope of services characteristically grouped under SGN.

Respondent 56: There is much more to be gained from standardization under SG than to remain as is now - at each individual SG's discretion. Some SG's simply look on it (if optional) as being stuck with one more OER to write and many more to endorse. Also, under SG, well-qualified, dynamic nurses would have greater opportunity for upper echelon endorsements.

Respondent 57: Definitely does not have the training or understanding of nursing problems which invariably is considered less than those of medical staff. Feel present situation works only because of a good rapport between SGH and SGHN.

Respondent 58: No, especially at a small facility where the SGH is often fulfilling the duties of that office for the first time. He/she concentrates on just learning the mechanics of the job. His/her primary concerns, in addition to the patients, are the providers, not the nursing staff. NOTE: This facility has recently submitted a request to command to change the organizational structure in this clinic so the Chief Nurse works for the DBMS. This waiver in organizational structure was approved and will become effective 1 Dec 86.

Respondent 59: Many times the SGHN is more knowledgable than the SGH - this is especially true in smaller facilities.

Respondent 60: With the change of Command Surgeon, waivers are no longer approved for Chief Nurses to come under the Hospital Commander. We find ourselves in the position of working under physicians who are new in the AF and have no management background. Nursing Services is a very important function of the hospital and we should be recognized as a 3-letter Chief equivalent to the MSC's and Dental. We are also the most experienced member of the executive team. It has been my experience here and at other assignments that Nursing Service is not supported by SGH. Is is one of the areas that you have the least support from.

Respondent 61: He is too busy with his job to even be aware of SGHN issues let alone take care of anything. "Isn't that why you have a Chief Nurse." Most also don't have the experience to know where to start let alone track SGN interests. Mine has enough problems trying to keep up with his job.

Respondent 62: I think my SGH has the desire to support SGHN and usually does when I ask bu-, does lack the training as this is a first assignment in this position. Does have some time but may not be adequate due to other concern on clinic situation.

Respondent 63: My office symbol is SGHN but I report directly to the Commander. However, if I worked for SGH I do not feel he has the time or training to act on behalf of Nursing. The Chief Nurse should work directly for the Commander since this individual is the expert on nursing issues. I have already dealt with the frustration of working with SGH and his lack of understanding and interpretation of JCAH standards. Therefore, understanding nursing standards on his part is nil.

Respondent 64: Yes, mostly because of the personality and rank of my current SGH. In a previous assignment this was not true and generally I feel that in smaller hospitals, SGH's do not have either the experience, training, or rank to be able to supervise the Chief Nurse nor to represent the best interests of Nursing Services.

Respondent 65: Most SGH's have little management experience and are in a transition phase in their careers. Many do not want the position. The aggressive nurse would probably fair OK, as she would write her own OER's, etc. The less experienced nurse would be at a tremendous disadvantage which could have a serious effect on his/her career.

Respondent 66: Generally speaking, SGH's and SG's are not educated as to their own role and responsibilities much less that of nursing. If SGH's are trained properly they are very effective and work hand in hand with nursing. In any case, it is decadent for Chief Nurses to be working for Chief of Professional Services.

Respondent 67: The present SGH - Yes. The immediate past SGH - no. The best interests of the Department of Nursing must be looked after by Nursing. Since we are usually the largest service or department, we should be a lateral office - reporting to SG.

Respondent 68: Desire - not always. He's everloaded as it is. Training - not usually as I have more management experience than SGH.

Respondent 69: Our SGH also pulls a full patient clinic, in addition to SGH duties. A training program would benefit all those who assume SGHN duties. My experience has been the senior ranking MC officer is assigned to this function; with seniority being the only criteria for SGH position.

Respondent 70: Being part-time SGH, with a heavy patient load, many providers, and a lot of time involved with credentialing, he has no time to be concerned about Nursing Services. I do not consistently communicate things to him and he doesn't ask. I communicate items of interest about Nursing Services at morning report and directly to the Commander.

Respondent 71: Although I function as an SGN, I have been in organizations that had a SGHN system. In my case, I outrank the SGH, plus, due to the size of the facility, he functions as SGH on a part-time basis. He is very sharp and we work together and he is supportive. However, he does not have time or training to do more than he is doing. With the current demands of QA, the SGH has more than enough to do without taking on nursing in a full-time supervisory role. In most hospitals in the AF, the SGH's are relatively inexperienced in their role and nursing has more to teach them than they have to teach us.

Respondent 72: Most SGH's that I know take a paternalistic attitude toward nursing. A quote from a new SGH to seasoned SGHN (not me), "You're the Nurse and I am the Doctor, you will do what I say." Management? The command SG takes the attitude that these "physician executives" need to be taught the job. At the expense of the nursing department. Little things occur that most of us do not think about: 1) Civilian personnel informed me that when my secretary leaves, I must hire a less qualified one, because SGHN secretary can not be as qualified as SGH secretary. 2) Parking is not available for 4-letter office symbols. However, in the absence of SGH, I am Chief, Department of Nursing and function as SGH and SGN. A little incongruent when one considers all the physician department heads. I believe that single largest factor of dissatisfaction in OS hospitals for nursing is the SGN SGH controversy.

END

7-87

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